Baltimore City Health Department
Ryan White CARE Act, Title I
Quality Improvement Program (QIP)

Service Category: Case Management
Final Report
June 2002

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Signature **Date**

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Section 1. Introduction

The Quality Improvement Program (QIP) began in FY 2001 for the Baltimore EMA, the purpose of which is to ensure that people living HIV/AIDS (PLWH/A) in the EMA have access to quality care and services consistent with the Ryan White CARE Act. Phase I of the QIP initiative focused on adult/adolescent primary care and case management services. To assess the degree to which the Standards of Care are adhered to across the EMA, baseline data was gathered and analyzed from all Title I funded adult/adolescent primary care and case management vendors in the EMA. Information presented in this report focuses exclusively on case management services.

Section 2. Methodology

QIP reviews were conducted at 100% of the 17 agencies providing case management services. Data was collected through three avenues: 1) agency survey; 2) client chart abstraction; and 3) consumer surveys.

Agency Survey: Agency surveys were completed by 100% of the case management vendors. The tool is a self-report of how well the agency complies with the EMA Case Management Standards of Care. No additional verification of information was undertaken. The contact person for the agency was responsible for completing the agency tool. Information related to the agency survey is presented Section 6.

Client Chart Abstraction: The chart abstraction tool was designed to assess the vendor's adherence to the Standards of Care as established by the Baltimore EMA. The review period focused on services provided in calendar year 2001 (CY 2001) for Title I clients. Vendors were instructed to have charts available for review using the following parameters:

Title I Eligibility
100% of charts should reflect Title I clients.
CD4 Counts
1/3 of charts should include clients with CD4 counts >500 cells/mm^3. 1/3 of charts should include clients with CD4 counts 200-500 cells/ mm^3. 1/3 of charts should include clients with CD4 counts < 200 cells/ mm^3.
Gender
1/3 of charts should represent women.
Service Initiation
At least five charts should represent services initiated in CY 2001; and five charts should represent closed files.

For each chart reviewed one survey instrument was completed. A total of 466 case management charts were reviewed. The number of charts reviewed per site ranged from 10 to 46 with an average of 27 charts reviewed. Information about the client chart abstraction is presented in Section 4.

Client Survey: The Consumer Instrument was designed to be completed by the clients. As needed, the Consumer Interviewer completed the tool while posing the questions to the clients. The tool focused on three primary areas: a) primary care; b) case management; and c) personal involvement with the agency. The questions emphasized the type of services provided and client's knowledge about their care rather than on their satisfaction with services. Information related to consumer surveys will be summarized in a separate report.

A total of 466 case management charts were reviewed at 17 agencies funded to provide case management services to Ryan White CARE Act Title I clients. All of the agencies funded through Title I participated in the one or two day review [Table 1].

TABLE 1. CASE MANAGEMENT AGENCIES REVIEWED, DATES OF REVIEW AND NUMBER OF CASE MANAGEMENT RECORDS REVIEWED

Agency Name	Dates of review	Number of records reviewed	% of QIP total
Anne Arundel County Health Department	02/14-15/2002	32	7%
Baltimore County Health Department	04/05/2002	25	5%
Bon Secours Hospital	01/24-25/2002	23	5%
Bon Secours Liberty Medical Center	02/14-15/2002	24	5%
Chase Brexton Health Services/Cathedral	01/29-30/2002	46	10%
Chase Brexton Health Services/Pikesville	01/31 - 2/1/2002	21	5%
Harford County Health Department	03/7-8/2002	31	7%
Health Care for the Homeless	02/19-20/2002	27	6%
HERO	02/21-22/2002	36	8%
JHU/Moore Clinic	03/13-14/2002	19	4%
JHU/Pediatric AIDS Clinic	02/13/2002	29	6%
People's Community Health Center	02/21-22/2002	27	6%
Queen Anne's County Health Department	03/07/2002	10	2%
Sisters Together and Reaching (STAR)	01/31 – 2/1/2002	22	5%
South Baltimore Family Health Center	02/21-22/2002	35	8%
UMD/Evelyn Jordan Center	02/28 – 3/1/2002	34	7%
UMD/PACE Clinic	03/06/2002	25	5%
TOTAL		**466**	**100%**

Based on data reported to BCHD by the agencies receiving Title I funding for case management, a total of 1,327 persons received case management services during the contract period covering March 1, 2001 to February 28, 2002.[1] While the QIP process reviewed client charts for CY 2001, comparisons are made between the reported data and the QIP data in Table 2. **Thirty-three percent (33.3%) of all case management**

[1] The number of Title I case management clients served by agency is based on reports provided by the vendors to BCHD, and cover the period March 1, 2001 to February 28, 2002. This total is unduplicated at the vendor level, and then aggregated to give a duplicated EMA-wide client count.

charts were reviewed during the QIP process. The range of proportion of an agency's charts that reviewed ranged from 121% to 11%, with an average of 45%.[2]

TABLE 2. PROPORTION OF CASE MANAGEMENT CLIENTS AND CHARTS REVIEWED: QIP VS. REPORTED EMA TITLE I CLIENTS

Agency Name	Number of charts reviewed during QIP	% of QIP Total	Reported # of Title I case management clients	% of agency's clients reviewed by QIP
Anne Arundel County Health Department	32	7%	92	35%
Baltimore County Health Department	25	5%	50	50%
Bon Secours Hospital	23	5%	61	39%
Bon Secours Liberty Medical Center	24	5%	198	12%
Chase Brexton Health Services/Cathedral	46	10%	77	62%
Chase Brexton Health Services/Pikesville	21	5%	151	14%
Harford County Health Department	31	7%	24	121%
Health Care for the Homeless	27	6%	37	73%
HERO	36	8%	74	49%
JHU/Moore Clinic	19	4%	121	16%
JHU/Pediatric AIDS Clinic	29	6%	46	63%
People's Community Health Center	27	6%	63	43%
Queen Anne's County Health Department	10	2%	16	63%
Sisters Together and Reaching (STAR)	22	5%	202	11%
South Baltimore Family Health Center	35	8%	59	9259
UMD/Evelyn Jordan Center	34	7%	115	30%
UMD/PACE Clinic	25	5%	96	25%
TOTAL	**466**	**100%**	**1482**	**33%**
Mean	**27.4**		**85.1**	**45%**
Min	**10**		**16**	**11%**
Max	**48**		**202**	**121%**

Clients have been receiving case management services from their agency for a mean of 25.5 months [Table 3]. The longest mean length of service at an agency is 42.6 months, the shortest, 5.7 months. Length of service was determined from the date the chart was opened by the case management agency to the date of closure in CY 2001, or to 12/31/01 for charts which were not closed.

[2] Vendors were requested to provide only their Title I client charts for review. At one agency, the number of charts provided exceeded the number of clients receiving case management services reported to BCHD.

TABLE 3. MEAN LENGTH OF CASE MANAGEMENT SERVICE BY AGENCY

Agency Name	Mean number of months of service	Min	Max
Anne Arundel County Health Department	38.5	2	92
Baltimore County Health Department	32.4	4	117
Bon Secours Hospital	19.4	2	47
Bon Secours Liberty Medical Center	34.7	1	92
Chase Brexton Health Services/Cathedral	33.0	2	105
Chase Brexton Health Services/Pikesville	42.6	2	114
Harford County Health Department	27.7	2	110
Health Care for the Homeless	29.7	5	87
HERO	27.4	1	84
JHU/Moore Clinic	11.3	1	93
JHU/Pediatric AIDS Clinic	18.8	2	96
People's Community Health Center	37.3	5	102
Queen Anne's County Health Department	26.5	11	38
Sisters Together and Reaching (STAR)	16.3	3	34
South Baltimore Family Health Center	5.7	2	9
UMD/Evelyn Jordan Center	16.1	1	49
UMD/PACE Clinic	14.2	2	58
TOTAL	**25.5**	**1**	**117**

Clients who began their case management services during CY 2001 (n=255) were expected to have completed the initial phases of case management (e.g, intake, assessment, client plan development). For these clients, the QIP review assessed the entire case management process. Of the 466 charts reviewed, approximately, one-half of the reviewed charts (51%) were opened prior to January 1, 2001, the beginning of the QIP review period. For the charts that were opened prior to the QIP review period, the QIP review began at the implementation and monitoring phases.

TABLE 4. NUMBER AND PROPORTION OF CASE MANAGEMENT CHARTS OPENED PRIOR TO 1/1/01 AND AFTER 1/1/01 BY AGENCY

Agency Name	**Chart opened prior to 1/1/01** # (% of row)	Chart opened after 1/1/01 # (% of row)	Missing/Not documented # (% of row)	Total number of charts reviewed
Anne Arundel County Health Department	25 (78%)	7 (22%)		32
Baltimore County Health Department	17 (68%)	8 (32%)		25
Bon Secours Hospital	16 (67%)	8 (33%)		23
Bon Secours Liberty Medical Center	15 (63%)	9 (37%)		24
Chase Brexton Health Services/Cathedral	29 (60%)	18 (38%)	1 (2%)	46
Chase Brexton Health Services/Pikesville	17 (81%)	4 (19%)		21
Harford County Health Department	20 (56%)	16 (44%)		31
Health Care for the Homeless	13 (45%)	16 (55%)		27
HERO	11 (41%)	16 (59%)		36
JHU/Moore Clinic		19 (100%)		19
JHU/Pediatric AIDS Clinic	10 (35%)	18 (62%)	1 (3%)	29
People's Community Health Center	19 (70%)	8 (30%)		27
Queen Anne's County Health Department	9 (90%)	1 (10%)		10
Sisters Together and Reaching (STAR)		35 (100%)		35
South Baltimore Family Health Center	12 (54%)	10 (46%)		22
UMD/Evelyn Jordan Center	17 (50%)	17 (50%)		34
UMD/PACE Clinic	9 (38%)	15 (62%)		25
TOTAL	**239 (51%)**	**225 (48%)**	**2 (<1%)**	**466**

Section 3. Client demographics

Of the 466 case management charts reviewed, 55 (12%) of these clients were pediatric clients, and 411 (88%) adult clients. Pediatric clients include those clients seen at the two identified pediatric care programs, and one child seen by another provider. Demographic data for each population are presented separately.

ADULT DEMOGRAPHICS

Gender

Two-thirds of the adult clients (66.2%) are male, one-third female (33.2%). Two clients are identified as transgender (0.5% of valid total). Gender could not be determined or was missing for eight of the client records. The distribution of QIP case management records by gender is similar to the distribution of the HIV/AIDS prevalence within the Baltimore City.[3]

Summary of comparison between QIP adults and Baltimore City HIV/AIDS prevalence[4]

	ADULT QIP CASE MANAGEMENT CHARTS REVIEWED[5]	BALTIMORE CITY HIV/AIDS PREVALENCE
% ADULT MALE	66.2%	63.3%
% ADULT FEMALE	33.2%	36.4%
% AGES 30 – 49 YEARS	76%	73.8%
% AGES 50 – 59 YEARS	14%	6.4%
% AFRICAN-AMERICAN	78%	82.6%
% WHITE	12%	9.2%
% HIV, NOT AIDS DIAGNOSIS	54%	54.6%
% AIDS	35%	45.3%

Age

The mean age of adult clients is 42.9 years, with males being slightly older than females (43.6 vs. 41.3 years) [Tables 5 & 6]. QIP clients represent an older population than the HIV/AIDS prevalence. While more than three-quarters (76%) of clients are between the ages of 30-49, 73.8% of the reported HIV/AIDS prevalence, 44% of the QIP clients are in the 40-49 years range, compared with 29.8% of the reported HIV/AIDS prevalence. Additionally, 14% of the QIP clients are in the 50-59 years range, 6.4% of the reported HIV/AIDS prevalence[6] [Table 5].

[3] Baltimore City Health Department, HIV Disease Surveillance Program, "Baltimore City HIV/AIDS Epidemilogical Profile", Third Quarter 2001, Section V.
[4] "Baltimore City HIV/AIDS Epidemilogical Profile".
[5] Missing/Not document data fields are included in the calculation of proportions.
[6] "Baltimore City HIV/AIDS Epidemilogical Profile", Section IV.

African-Americans are slightly older than the mean QIP client age (43.7 years vs. 42.9), with Asian/Pacific Islander clients, and "Other" the youngest clients (33.5 and 36.6 years, respectively) [Table 8].

TABLE 5. AGE RANGE DISTRIBUTION, MEAN AGE, ADULT CASE MANAGEMENT CLIENTS

Age range	Total # (% of column)
13 to 19 years	1 (< 1%)
20 – 29	21 (5%)
30 – 39	121 (32%)
40 – 49	181 (44%)
50 – 59	58 (14%)
60 – 69	9 (2%)
> 70	2 (< 1%)
Missing/Not documented[7]	8 (2%)
Total	411 (100%)
Mean age (yrs)	42.9
Min – Max (yrs)	19.8 – 85.5

TABLE 6. AGE RANGE DISTRIBUTION, BY GENDER, ADULT CASE MANAGEMENT CLIENTS

Age range	Male # (% of column)	Female	Transgender	Missing/Not documented	Total # (% of column)
13 - 20	1 (<1%)				1 (< 1%)
20 – 29	11 (4%)	10 (8%)			21 (5%)
30 – 39	79 (30%)	50 (38%)		2 (25%)	121 (32%)
40 – 49	122 (46%)	54 (42%)	1 (50%)	4 (50%)	181 (44%)
50 – 59	44 (17%)	11 (9%)	1 (50%)	2 (25%)	58 (14%)
60 – 69	5 (2%)	4 (3%)			9 (2%)
> 70	1 (<1%)	1 (<1%)			2 (< 1%)
Missing/Not documented					8 (2%)
Total (% of row)	**263 (65%)**	**130 (32%)**	**2 (<1%)**	**8 (2%)**	**411 (100%)**
Mean age (yrs)	**43.6**	**41.4**	**41.4**		
Min - max (yrs)	**19.8 – 79.6**	**21.8 – 85.5**	**49.9 – 53.4**		

Race/Ethnicity

Seventy-eight percent (78%) of adult clients are African-American, with whites being the second largest group, representing 12% of the total. A few charts of Hispanic, Asian/Pacific Islander and Native American clients were reviewed; all of the clients in the "other" race category are from African countries [Table 7].

[7] "Missing/Not documented" refers to data either: 1) missing from the chart; or 2) not documented on the Case Management Instrument. These values were included when calculating percentages.

Among adults with HIV/AIDS residing in Baltimore City, 82.6% are African-American and 9.2% Caucasian. Charts reviewed during the QIP process reflected 78% African-American clients and 12% Caucasian and represent clients from Baltimore City and the surrounding counties. Clients from the surrounding counties which tend to be more white and less African-American than the clients from Baltimore City.[8] Compared with the case management client data provided by the Title I case management agencies, 64% of clients receiving case management services are African-American; the sample of case management charts reviewed contained a higher proportion of African-American clients.[9]

The gender distribution of African-American clients is more similar to the overall gender distribution than that of whites, which tends to be more male [Table 8].

TABLE 7. RACE/ETHNICITY DISTRIBUTION, ADULT CASE MANAGEMENT CLIENTS

Race/Ethnicity	Total # (% of column)
African-American	322 (78%)
White	48 (12%)
Hispanic	6 (2%)
Asian/Pacific-Islander	4 (1%)
Native American	2 (<1%)
Other	8 (2%)
Missing/Not documented	21 (5%)
TOTAL	411 (100%)

TABLE 8. RACE/ETHNICITY AND GENDER DISTRIBUTION, ADULT CASE MANAGEMENT CLIENTS

Race/Ethnicity	Male # (% of column)	Female	Trans-gender	Missing/Not documented	Total # (% of column)	Mean age (years)
African-American	202 (63% of row)	110 (34%)	2 (<1%)	8 (3%)	322 (78% of column)	43.7
White	35 (75%)	12 (25%)			48 (12%)	40.4
Hispanic	6 (100%)				6 (2%)	38.5
Asian/Pacific-Islander	2 (50%)	2 (50%)			4 (1%)	48.7
Native American	1 (50%)	1 (50%)			2 (<1%)	33.5
Other	5 (63%)	3 (37%)			8 (2%)	36.6
Missing/Not documented	11 (52%)	4 (19%)		6 (29%)	21 (5%)	
TOTAL	**263 (64%)**	**132 (32%)**	**2 (<1%)**	**14 (4%)**	**411 (100%)**	**42.9**

[8] "Baltimore City HIV/AIDS Epidemilogical Profile", Section V.

[9] Title I case management data provided by BCHD and is based on agency reported data, covering the period March 1, 2001 to February 28, 2002. Data was available for 16 of the 17 agencies reviewed during the QIP process. Proportions are calculated based on the data provided by the agencies.

Transmission Risk

Twenty-six percent (26%) had injecting drug use (IDU) documented as their risk factor for HIV infection, and heterosexual contact was the second most frequent response, 24% [Table 9]. Among men, IDU was the most common risk factor, followed by men who have sex with men (MSM) 23%. Among women, 42% were infected through heterosexual contact, followed by injecting drug use (24%), and heterosexual contact and IDU at 14%. Documentation of transmission risk was more complete for women than for men.

TABLE 9. TRANSMISSION RISK DISTRIBUTION BY GENDER, ADULT CASE MANAGEMENT CLIENTS

Transmission risk	Male # (% of column)	Female	Transgender	Missing/Not documented	Total # (% of column)
Injecting drug user (IDU)	74 (28%)	31 (24%)		1 (7%)	106 (26%)
Heterosexual contact	40 (15%)	56 (42%)		1 (7%)	97 (24%)
Heterosexual contact and IDU	12 (5%)	18 (14%)			30 (7%)
Men who have sex with men (MSM)	61 (23%)		1 (50%)	2 (14%)	64 (16%)
Hemophilia	5 (2%)	2 (2%)			7 (2%)
MSM and IDU	7 (3%)				7 (2%)
Perinatal transmission				1 (7%)	1 (<1%)
Other	4 (2%)	6 (5%)		1 (7%)	11 (3%)
Missing/Not Documented	52 (20%)	16 (12%)	1 (50%)	8 (57%)	77 (19%)
Unknown	8 (3%)	3 (2%)			11 (3%)
Total (% of row)	**263 (100%)**	**132 (100%)**	**2 (100%)**	**14 (3%)**	**411 (100%)**

Clinical and treatment indicators

In an effort to examine clinical and treatment indicators, QIP reviewers were asked to document clients' laboratory values (CD4 and viral load), disease status, and whether the client was on highly active antiretroviral treatment (HAART) at two points during the review period—the first entry in the calendar year and the last entry in the calendar year. These two CD4 values were recorded from 158 charts (38% of total), two viral load measures from 139 (34%) charts, two disease status values from 388 charts (92%) disease status and two treatment status values from 311 (76%) charts.

Summary of documentation of two CY 2001 clinical and treatment indicators

	#/% OF TOTAL ADULT RECORDS WITH 2 CY 2001 INDICATORS
CD4	158 (38%)
VIRAL LOAD	139 (34%)
DISEASE STATUS	388 (92%)
HAART TREATMENT	311 (76%)

Disease status

The disease status was recorded at two periods during the review period. The tables below present the latest data from the review period. The majority of clients had an HIV-positive, not AIDS diagnosis (54%) of total, with 35% having a CDC-defined AIDS diagnosis and a total of 13 (3%) of clients dying during the review period. The disease status was not documented for 8% of the clients. This end-of-review period distribution is similar to the HIV/AIDS prevalence, with 54.6% of living cases being HIV-positive, not AIDS, and 45.3% being AIDS diagnosed[10] [Table 10].

In this sample, African-Americans were more likely to have an AIDS diagnosis, than whites (35% vs. 31% of the disease status distribution within each racial category). Additionally, eleven of the thirteen clients who died (85%) were African-American. The disease status of 9% of African-Americans was not documented. [Table 11].

The majority of women (55%) were HIV-infected, not AIDS clients, with 34% having an AIDS diagnosis. Forty-five percent of men were HIV-infected, not AIDS clients, and 37% had an AIDS diagnosis. Ten of the 13 clients (77%) who died were male [Table 12].

Compared with the Baltimore City prevalence data, the client population reviewed had a smaller proportion of CDC-defined AIDS clients and more HIV-infected, not AIDS clients.[11] It is likely that a greater number of the case management clients had progressed to an AIDS diagnosis. During the QIP review process, it was noted that clients' disease status was not routinely documented and updated. Often, disease status was determined by the reviewers from entries made in application forms for entitlements and other services.

[10] "Baltimore City HIV/AIDS Epidemilogical Profile", Section IV.
[11] "Baltimore City HIV/AIDS Epidemilogical Profile", Section IV.

TABLE 10. DISEASE STATUS DISTRIBUTION, ADULT CASE MANAGEMENT CLIENTS

Disease status	Total # (% of column)
HIV-positive, not AIDS	222 (54%)
CDC-defined AIDS	143 (35%)
Deceased	13 (3%)
Missing/Not documented	33 (8%)
Total	411 (100%)

TABLE 11. DISEASE STATUS DISTRIBUTION BY RACE/ETHNICITY, ADULT CASE MANAGEMENT CLIENTS

Disease status	African-American # (% of column)	White	Hispanic	Asian/Pacific-Islander	Native American	Other	Missing/Not documented	Total #
HIV-positive, not AIDS	170 (53%)	32 (67%)	3 (50%)	3 (75%)	1 (50%)	4 (50%)	9 (43%)	222 (54%)
CDC-defined AIDS	113 (35%)	15 (31%)	3 (50%)	1 (25%)	1 (50%)	4 (50%)	6 (29%)	143 (35%)
Deceased	11 (3%)	1 (2%)					1 (5%)	13 (3%)
Missing/Not documented	28 (9%)						5 (24%)	33 (8%)
Total (% of row)	322 (78%)	48 12%)	6 1%)	4 <1%)	2 <1%)	8 2%)	21 (5%)	411 (100%)

TABLE 12. DISEASE STATUS DISTRIBUTION BY GENDER, ADULT CASE MANAGEMENT CLIENTS

Disease status	Male # (% of column)	Female	Transgender	Missing/Not documented	Total # (% of column)
HIV-positive, not AIDS	144 (45%)	72 (55%)	1 (50%)	5 (36%)	222 (54%)
CDC-defined AIDS	96 (37%)	45 (34%)		2 (14%)	143 (35%)
Deceased	10 (4%)	2 (2%)	1 (50%)		13 (3%)
Missing/Not documented	13 (5%)	13 (10%)		7 (50%)	33 (8%)
Total (% of row)	263 (64%)	132 (32%)	2 (100%)	14 (3%)	411 (100%)

Laboratory values

Slightly more than one-quarter, (27%), the largest proportion of clients had a CD4 value in the 250-500 range (cells/mm^3). Nine percent had (9%) a CD4 value of less than 50, indicating advanced disease progression and the highest risk for opportunistic infections [Table 13]. More than one quarter (28%), the largest proportion of clients, had a viral load that was undetectable [Table 14]. A large number of records did not include information relating to CD4 count (20%) or viral load (26%).

TABLE 13. CD4 RANGE, LAST ENTRY, ADULT CASE MANAGEMENT CLIENTS

CD4 range (cells/mm^3)	Total # of clients # (% of column)
‹50	35 (9%)
50-100	24 (6%)
101-249	65 (16%)
250-500	112 (27%)
501-1000	78 (19%)
›1,000	15 (4%)
Missing/Not documented	82 (20%)
Total	**411**

TABLE 14. VIRAL LOAD RANGE, LAST ENTRY, ADULT CASE MANAGEMENT CLIENTS

Viral load range	Total # of clients # (% of column)
Undetectable	114 (28%)
51 - 999	23 (5%)
1,000 – 5,000	27 (7%)
5,001 – 20,000	42 (10%)
20,000 – 100,000	57 (14%)
› 100,000	43 (11%)
Missing/Not documented	105 (26%)
Total	**411 (100%)**

Treatment status

Data was collected on whether a client was on highly active antiretroviral therapy (HAART), which consists of three or more antiretrovirals, as defined by the U.S. Public Health Services, "Guidelines for the use of Antiretroviral Agents in HIV Infected Adults and Adolescents"[12], at the first and last entries for CY 2001.

Overall, 58% of clients were treated with HAART during CY 2001, while 18% were not. Of those with an AIDS diagnosis, 69% were treated with HART, and 15% were not. Treatment status is not known for the remaining clients [Table 15].

[12] U.S. Department of Health and Human Services, *Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents,* August 13, 2001.

Tables 15-17 provide data on disease status, CD4 levels, and viral loads, for those 237 clients who were determined to have been treated with HAART at any time during CY 2001 and for those 74 who were not on HAART during CY 2001. [Note: Patients whose treatment status was unknown are not reported in these tables.]

TABLE 15. TREATMENT WITH HAART BY DISEASE STATUS, LAST ENTRY, ADULT CASE MANAGEMENT CLIENTS

Disease status	Total # of clients # (% of column)	#/% Clients on HAART during CY 2001 (% of row)	#/% Clients not on HAART during CY 2001 (% of row)
CDC-defined AIDS	143 (35%)	98 (69%)	22 (15%)
Dead	13 (3%)	4 (31%)	2 (15%)
HIV-positive, not AIDS	222 (54%)	127 (57%)	49 (22%)
Missing/Not documented	33 (8%)	8 (24%)	1 (<1%)
Total	**411 (100%)**	**237 (58%)**	**74 (18%)**

A total of 124 clients (31%) had a CD4 count below 249. Of these, 64% were known to be on HAART during CY 2001, and 19% were not on HAART during CY 2001. For clients with CD4 counts between 250-500, similar proportions were noted [Table 16].

TABLE 16. TREATMENT WITH HAART BY CD4 RANGE, LAST ENTRY, ADULT CASE MANAGEMENT CLIENTS

CD4 range (cells/mm^3)	Total # of clients # (% of column)	#/% Clients on HAART during CY 2001 (% of row)	#/% Clients not on HAART during CY 2001 (% of row)
<50	35 (9%)	16 (46%)	9 (26%)
50-100	24 (6%)	18 (75%)	3 (13%)
101-249	65 (16%)	45 (69%)	12 (18%)
250-500	112 (27%)	71 (63%)	20 (18%)
501-1000	78 (19%)	47 (60%)	20 (26%)
>1,000	15 (4%)	8 (53%)	6 (40%)
Missing/Not documented	82 (20%)	32 (39%)	4 (5%)
Total	**411**	**237 (58%)**	**74 (18%)**

Eighty-two percent (82%) of clients with an undetectable viral load were treated with HAART during CY 2001, while 7% were not. Twenty-four percent (24%) of clients had a viral load greater than 20,000; of these, 45% were known to be treated with HAART, and 34% were not [Table 17].

TABLE 17. TREATMENT WITH HAART BY VIRAL LOAD RANGE, LAST ENTRY, ADULT CASE MANAGEMENT CLIENTS

Viral load range	Total # of clients # (% of column)	#/% Clients on HAART during CY 2001 (% of row)	#/% Clients not on HAART during CY 2001 (% of row)
Undetectable	114 (28%)	94 (82%)	8 (7%)
51 - 999	23 (5%)	17 (73%)	3 (14%)
1,000 – 5,000	27 (7%)	17 (63%)	3 (11%)
5,001 – 20,000	42 (10%)	23 (55%)	13 (31%)
20,001 – 100,000	57 (14%)	28 (49%)	19 (33%)
› 100,000	43 (11%)	17 (40%)	15 (36%)
Not documented in chart	105 (26%)	41 (39%)	13 (12%)
Total	411 (100%)	237 (58%)	74 (18%)

Clinical outcomes

As described above, reviewers sought documentation of two CD4 and viral load laboratory values from CY 2001. The tables below present data relating to those clients for whom these two variables were recorded. These biological markers are used to determine client-level outcomes. Improved or maintained CD4 counts and viral loads indicate improved health status of persons with HIV/AIDS, the major goal of the Federal Ryan White CARE Act.

A total of 158 adult clients had CD4 counts documented at two points (38% of charts reviewed). For those clients, the mean CD4 value was 376.5 at the first entry and 388.8 at the second. There was a mean increase of 12.36 or 3.3% from the first to last value. Overall, 58% experienced an increase in CD4 count from the first to last entry, while 41% experienced a decrease, and 2% experienced no change. Table 18 presents additional data by treatment status, gender and race.

Slightly more than three-quarters (78%) of clients with two CD4 values were on HAART during CY 2001. Clients who were not treated during CY 2001 had a higher mean CD4 and an greater mean increase from the first to last value. African-American clients had higher mean CD4 values than those of Caucasians and Hispanics; however, Caucasians had a larger mean increase, and Hispanics had a mean decrease in CD4 value. Women and men had similar mean CD4 values, although men had a greater increase in CD4 value [Table 18]. (Values for Asian/Pacific Islanders, Native Americans, "Other" racial category, and transgender are not presented because the n=1.)

TABLE 18. MEAN CD4 COUNTS OF ADULT CASE MANAGEMENT CLIENTS FOR WHOM THERE ARE TWO CD4 VALUES FROM CY 2001, BY TREATMENT STATUS, GENDER AND RACE

	Mean CD_4 first value	Mean CD_4 second value	Mean change
All clients with two CD_4 values (n=158)	376.5	**388.8**	+ 12.36 + 3.3%
Treatment status (n=138)			
On HAART during CY 2001 (n=107)	359.9	371.5	+ 11.6 + 3.2%
Not on HAART during CY 2001 (n=31)	435.6	459.0	+ 23.4 + 5.3%
Gender (n=155)			
Male (n=109) [40% of males' charts reviewed]	373.2	389.7	+ 16.5 + 4.4%
Female (n=46) [34% of females' charts reviewed]	380.5	384.8	+ 4.3 + 1.1%
Race (n=149)			
African-American (n=124) [39% of African-Americans' charts reviewed]	391.8	410.2	+ 18.4 + 4.6%
White (n=17) [35% of Whites' charts reviewed]	322.6	363.9	+ 41.3 + 12.8%
Hispanic (n=5) [83% of Hispanics' charts reviewed]	197.2	164.0	-33.2 -16.8%%

Table 19 shows the CD4 range distribution for the 158 clients for whom there are two values. There are slight shifts the distribution from the first entry to the second entry.

TABLE 19. CD4 RANGE DISTRIBUTION OF ADULT CASE MANAGEMENT CLIENTS FOR WHOM THERE ARE TWO CD4 VALUES FROM CY 2001

CD4 range (cells/mm^3)	First entry Total # of clients # (% of column)	Last entry Total # of clients # (% of column)
‹50	20 (13%)	15 (10%)
50-100	8 (5%)	13 (8%)
101-249	27 (17%)	25 (16%)
250-500	52 (33%)	59 (37%)
501-1000	47 (30%)	40 (25%)
›1,000	4 (3%)	6 (4%)
Total	158 (100%)	158 (100%)

Table 20 shows the viral load range distribution for the 139 clients for whom there are two values. There are slight shifts in the distribution from the first entry to the second entry.

TABLE 20. VIRAL LOAD RANGE DISTRIBUTION OF ADULT CASE MANAGEMENT CLIENTS FOR WHOM THERE ARE TWO VIRAL LOAD VALUES FROM CY 2001

Viral load range	First entry Total # of clients # (% of column)	Last entry Total # of clients # (% of column)
Undetectable	54 (39%)	56 (40%)
50 - 999	8 (6%)	12 (8%)
1,000 – 5,000	11 (8%)	10 (7%)
5,001 – 20,000	16 (12%)	20 (14%)
20,001 – 100,000	30 (22%)	30 (21%)
› 100,000	10 (14%)	12 (9%)
Total	139 (100%)	139 (100%)

Length of care

The majority of clients began their case management service prior to January 1, 2001 (53%). There was a slight variance by gender. However, a greater proportion of whites had their charts opened prior to January 1, 2001 (65% vs. 53% for the total group) [Table 22].

Length of service was determined from the date the chart was opened by the case management agency to the date of closure in CY 2001, or to 12/31/01 for charts which were not closed. The mean length of service for all adult clients is 26.65 months. In this sample, Caucasians have been in care longer than any other race group (39.04 months).

There is a slight variation in length of care between males and females (27.18 vs. 25.68 months). Clients who died during the review period were in care for a mean of 22.82 months, with clients with an HIV-positive diagnosis being in care longer than those with an AIDS-diagnosis (28.56 vs. 22.82 months). [Table 23]

TABLE 21. PROPORTION OF ADULT CASE MANAGEMENT CHARTS OPENED PRIOR TO 1/1/01 AND AFTER 1/1/01 BY GENDER

Gender	Chart opened prior to 1/1/01 # (% of row)	Chart opened after 1/1/01 # (% of row)	Missing/Not documented # (% of row)	Total number of charts reviewed (% of column)
Male	142 (54% of row)	120 (46%)	1 (<1%)	263 (64% of column)
Female	68 (51%)	64 (49%)		130 (32%)
Transgender	1 (50%)	1 (50%)		2 (<1%)
Missing/Not documented	8 (57%)	6 (43%)		14 (3%)
Total	**219 (53%)**	**191 (47%)**	**1 (<1%)**	**411 (100%)**

TABLE 22. PROPORTION OF ADULT CASE MANAGEMENT CHARTS OPENED PRIOR TO 1/1/01 AND AFTER 1/1/01 BY GENDER AND RACE/ETHNICITY

Race	Chart opened prior to 1/1/01 # (% of row)	Chart opened after 1/1/01 # (% of row)	Missing/Not documented # (% of row)	Total number of charts reviewed (% of column)
African-American	166 (52% of row)	155 (48%)	1 (<1%)	322 (78% of column)
White	31 (65%)	17 (35%)		48 (12%)
Hispanic	3 (50%)	3 (50%)		4 (1%)
Asian/Pacific-Islander	2 (50%)	2 (50%)		4 (1%)
Native American	1 (50%)	1 (50%)		2 (<1%)
Other	5 (63%)	3 (38%)		8 (2%)
Missing/Not documented	11 (52%)	10 (48%)		21 (5%)
Total	**219 (53%)**	**191 (47%)**	**1 (<1%)**	**411 (100%)**

TABLE 23. MEAN LENGTH OF CLIENT SERVICE BY RACE, GENDER AND DISEASE STATUS, ADULT CASE MANAGEMENT CLIENTS

	n	Mean length of service (months)
Adult clients	411	26.65
Race		
African-American	313	25.04
White	48	39.04
Hispanic	6	20.50
Asian Pac-Islander	4	15.75
Native American	2	23.5
Other	8	25.88
Gender		
Male	262	27.18
Female	132	25.68
Transgender	2	56.50

Disease status		
HIV-positive, not AIDS	217	28.56
CDC-defined AIDS	141	22.82
Dead	13	40.08

Insurance status

Data for this section was derived from clients whose insurance status was recorded at two time periods during the calendar year (first and last entry of the calendar year). At each period, the largest number of clients did not have health insurance, followed by the Maryland AIDS Drug Assistance Program (MADAP), Medicaid, Medicare and Private/Commercial insurance. Some clients received care through the Veteran's Administration. It was not uncommon for some clients to have multiple insurance providers, approximately 13% of clients (often these were Medicare and MADAP or another pharmacy program). Insurance data was missing/not documented for approximately 7% of clients. Fourteen percent (14%) of clients had a change in their insurance status from the first entry to the last [Table 24].

TABLE 24. INSURANCE COVERAGE DISTRIBUTION, ADULT CASE MANAGEMENT CLIENTS

Insurance n=411	First entry	Second entry
None	116	88
Missing/Not documented	30	32
MADAP	87	109
Medicaid	90	96
Medicare	57	59
Other (mostly other state pharmacy programs or primary care programs)	19	16
Private/Commercial	56	56
Veteran's Administration	11	11

Of the 116 clients who did not have health insurance at the first entry, 73% did not have insurance at the second entry; but nineteen percent of the uninsured gained access to HIV-related treatment through the MADAP program, while 4% obtained Medicaid coverage, and 3% private insurance coverage [Table 25].

TABLE 25. INSURANCE STATUS AT SECOND ENTRY OF THE 116 ADULT CASE MANAGEMENT CLIENTS WHO HAD NO INSURANCE AT TIME OF FIRST ENTRY IN CY 2001

Insurance n=116	Second entry
None	85
Missing/Not documented	1
MADAP	22
Medicaid	5
Medicare	0
Other (mostly other state pharmacy programs)	2

Private/Commercial	3
Veteran's Administration	0

Residence

The zip code of clients was recorded and a commercial zip code data base[13] was used as a "look-up table" to determine the city of residence based on this zip code. The largest number of people resided in Baltimore City during the year (31.1%). It is notable that several clients have zip codes outside of the Baltimore EMA yet were classified by case management vendors as being Title I clients.

TABLE 26. CITY OF RESIDENCE, ADULT CASE MANAGEMENT CLIENTS

City	# (% of column)
Baltimore	128 (31.1%)
Brooklyn Park	32 (7.8%)
Missing/Not documented	31 (7.5%)
Walbrook	16 (3.9%)
Druid	14 (3.4%)
Arlington	13 (3.2%)
Waverly	13 (3.2%)
Annapolis	10 (2.4%)
Govans	9 (2.2%)
Clifton East End	7 (1.7%)
Edgewood	7 (1.7%)
Havre de Grace	7 (1.7%)
West Case	7 (1.7%)
Carroll	6 (1.5%)
Foxridge	6 (1.5%)
East Case	5 (1.2%)
Franklin	5 (1.2%)
Aberdeen	4 (1.0%)
East End	4 (1.0%)
Glenburnie	4 (1.0%)
Northwood	4 (1.0%)
Pikesville	4 (1.0%)
South	4 (1.0%)
Woodlawn	4 (1.0%)4
Abingdon	3 (0.7%)
Catonsville	3 (0.7%)
Centreville	3 (0.7%)
Highlandtown	3 (0.7%)
Patterson	3 (0.7%)
Chestertown	2 (0.5%)
Clifton	2 (0.5%)
Darlington	2 (0.5%)
Essex	2 (0.5%)
Glen Burnie	2 (0.5%)
Hamilton	2 (0.5%)
Hampden	2 (0.5%)
Loch Raven Village	2 (0.5%)
Middle River	2 (0.5%)
Orchard Beach	2 (0.5%)
Queenstown	2 (0.5%)
Rosedale	2 (0.5%)
Windsor Mill	2 (0.5%)
Belcamp	1 (0.2%)
Beverley Beach	1 (0.2%)
Columbia	1 (0.2%)
Crofton	1 (0.2%)
Deale	1 (0.2%)
Dundalk	1 (0.2%)
Dundalk Sparrows Point	1 (0.2%)
Easton	1 (0.2%)
Forest Hill	1 (0.2%)
Glyndon	1 (0.2%)
Greenbelt	1 (0.2%)
Lothian	1 (0.2%)
Millersville	1 (0.2%)
Owings Mills	1 (0.2%)
Pasadena	1 (0.2%)
Queen Anne	1 (0.2%)
Raspeburg	1 (0.2%)
Riverside	1 (0.2%)
Riviera Beach	1 (0.2%)
Roland Park	1 (0.2%)
Severna Park	1 (0.2%)
Silver Spring	1 (0.2%)
Street	1 (0.2%)
Sudlersville	1 (0.2%)
Takoma Park	1 (0.2%)
Timonium	1 (0.2%)
Total	**411**

[13] ZIPList 5, purchased from zipinfo.com™, January 2002.

The table below provides demographic data by the HRSA reporting categories for adults, children and infants.

Table 27. age and race/ethnicity distribution by hrsa reporting categories

0 12 months	**27 (6% of charts reviewed)**
1 –12 years	**26 (6% of charts reviewed)**
13 – 24 years	**6 (1% of charts reviewed)**
Women >= 25 years	**128 (27% of charts reviewed)**
African-american women	**137 (29% of charts reviewed)**
African-american men	**220 (47% of charts reviewed)**

infant and child demographics

Fifty-five (11.8% of all charts reviewed) of the case management charts are of infants and children (<13 years) and 3 youth (13 – 19 years) who received case management services from the two agencies specializing in pediatric HIV/AIDS care and one child receiving case management services at another agency. Demographics from all of these charts are presented in this section.

Sixty-two percent (62%) of these charts were opened during CY 2001, and two (3.6%) were closed during CY 2001. Compared to adult clients, a greater proportion of infants' and children's charts were opened during CY 2001.

The mean age is 3.21 years, with a range of several months to 17.74 years old [Table 28]. Over four-fifths (81.8%) of clients are African-American [Table 29]. Over ninety percent (92.7%) of infants and children were at risk for perinatal infection [Table 31].

table 28. age distribution and mean age, infant and child case management clients

Gender	# (% of total)	Mean (years)	Minimum	Maximum
Female	31(56.4%)	3.42	0.13	16.99
Male	24 (43.6%)	2.93	0.22	17.74
Total	55 (100%)	3.21	0.13	17.74

table 29. racial distribution, infant and child case management clients

Race/Ethnicity	# (% of total)
African-American	45 (81.8%)
White	2 (3.6%)
Hispanic	2 (3.6%)
Other	1 (1.8%)
Missing/Not documented	5 (9.1%)
Total	55 (100%)

At the last disease status entry, 40% of the infants and children were HIV-infected, while 54.5% were still at the P0 classification, with three infants determined not to be infected.

TABLE 30. DISEASE STATUS DISTRIBUTION, INFANT AND CHILD CASE MANAGEMENT CLIENTS

Disease status	Last entry
HIV-infected	22 (40%)
PO	30 (54.5%)
HIV negative	3 (5.5%)
Total	**55 (100%)**

TABLE 31. TRANSMISSION DISTRIBUTION, INFANT AND CHILD CASE MANAGEMENT CLIENTS

Transmission	N (% of total)
Perinatal transmission	51 (92.7%)
Hemophilia	1 (1.8%)
Missing/Not documented	3 (5.4%)
Total	55 (100%)

Nearly all infants and children had Medicaid coverage during CY 2001, with a smaller proportion having this coverage at the last entry. None had multiple insurance coverage and 13% had private insurance coverage [Table 32].

TABLE 32. INSURANCE DISTRIBUTION AT FIRST AND LAST ENTRY, INFANT AND CHILD CASE MANAGEMENT CLIENTS

Insurance	First entry	Second entry
None	2	4
Missing/Not documented	3	3
Medicaid	43	41
Private/Commercial	7	7

The largest number of clients reside in Baltimore City, however it is important to note that several reside outside of the EMA [Table 33].

TABLE 33. CITY OF RESIDENCE, INFANT AND CHILD CASE MANAGEMENT CLIENTS

City	# (% of column)
Baltimore	15 (27.3%)
Arlington	4 (7.3%)
East Case	4 (7.3%)
Waverly	4 (7.3%)
Severn	3 (5.5%)
Arbutus	2 (3.6%)
Columbia	2 (3.6%)
Druid	2 (3.6%)
Highlandtown	2 (3.6%)
Walbrook	2 (3.6%)
Aberdeen	1 (1.8%)
Cambridge	1 (1.8%)
Carroll	1 (1.8%)

Clifton East End	1 (1.8%)
East End	1 (1.8%)
Essex	1 (1.8%)
Fairmont, WV	1 (1.8%)
Franklin	1 (1.8%)

Lewistown	1 (1.8%)
McLean, VA	1 (1.8%)
Olney	1 (1.8%)
Randallstown	1 (1.8%)
Raspeburg	1 (1.8%)

Russett	1 (1.8%)
York, PA	1 (1.8%)
Total	**55**

Section 4. Client-level assessment of compliance with EMA case management standards

PHASE 1: CLIENT IDENTIFICATION

Purpose and key activities of case management phase

Client identification is the beginning of the case management process. The client, or his/her agent, makes initial contact with the case management agency to indicate her/his interest in receiving services. The agency responds by determining whether the client meets the agency's eligibility for case management services. This screening may be done either in person or by telephone. If the client is determined to be eligible for services, then the case management process is initiated, and if not, then the agency is expected to provide a referral to another agency which can meet the client's presenting need.

The activities relating to the client identification phase generally occur prior to the opening of a case management record. During this phase, a prospective client or his/her agent contacts the agency to inquire about case management services. If an agency documents this inquiry, it may be included in the case management record; however, if an agency provides a referral to those clients not appropriate for the agency's services, then this action would not be documented in a client's chart.

Summary of findings

Because many of these activities occur prior to the opening of a client chart, assessing the compliance with the standard is probably best assessed through assessment of the agencies' policies and procedures for client identification rather than through chart assessment. Agencies should be encouraged to include the documentation of the initial client contact and screening in a subsequently opened case management record.

Based on the results of the agency survey (Section 6) 94% of agencies report having policies and procedures regarding eligibility for services.

PHASE 2: CLIENT INTAKE

Purpose and key activities of case management phase

For clients who are determined to be eligible for the agency's case management services, a case management intake is completed. The purpose of the intake is to initiate the partnership between the client and the agency/case manager. Clients are provided information regarding the case management services, the roles, rights, responsibilities and expectations of both the client and case manager, and informed consent to receive case management services is provided and other consents to request and share information is provided. During the intake process, information is collected to be used during the assessment process. Documentation of the intake is completed on the agency's intake forms which collect basic demographic data (including information used for contract-related reporting) and other client information.

Four standards are included in this case management phase.

Summary of findings

A total of 220 clients (47% of total number of reviewed records) had a documented case management intake completed after January 1, 2001. The level of case management is determined by the case manager based on the presenting need, and specifies expectations of frequency and type of case management-client contact, of these, nearly three-quarters were assessed at the "intensive" or "intermediate/periodic" level of case management. Very few clients, 6%, were assessed at "limited" or "one-time" level [Table 34].

TABLE 34. IDENTIFIED LEVEL OF CASE MANAGEMENT

Level of case management	Number (% of total)
Intensive	99 (45%)
Intermediate/Periodic	61 (28%)
Limited/One-time	13 (6%)
Missing/Not documented	45 (20%)
Total	**220 (100%)**

Sixty-three percent (63.3%) of the adults' charts contained a signed consent for release of information, while 54.3% contained a signed consent to receive case management services from the agency. Only 16.4% of the children's charts contained a signed consent for release of information, and only 5.5% had a signed consent to receive case management services.

Compliance with each of the four standards within Phase 2 are presented below.

	EMA Case Management Standard	Percent of reviewed charts meeting standard
2.2a [14]	Agency shall complete an initial assessment on eligible clients at time of intake; collecting all information outlined on agency's intake forms. *Completion of forms is **required** for **intensive** and **intermediate/periodic** case management.*	**80%**
2.2b	Clients presenting with emergency needs will have those needs addressed by the conclusion of the intake appointment.	**79%** **(n=94)** Note: 126 charts were excluded from analysis, because they did not have an emergency need identified at time of intake.
2.2c	Client will be seen for first case management appointment within **5 working days** after assignment to a case manager. Clients requiring an off-site visit must be seen within **10 working days** after assignment to case manager. Exceptions are made if client initiates cancellation.	**76%**
2.2d	Agency shall assist the client in identifying and making an appointment with a medical provider for those not already connected to a primary medical care provider. *Client is to schedule his/own own appointment if able.*	**82%** **(n=117)** Note: 103 charts were excluded from analysis, because clients already had an identified medical care provider (102) or declined assistance (1).

PHASE 3: PSYCHOSOCIAL NEEDS ASSESSMENT/RESOURCE IDENTIFICATION

Purpose and key activities of case management phase

During the Psychosocial Needs Assessment/Resource Identification phase the case manager utilizes the data collected during the intake process to evaluate the client's current level of functioning and needs, strengths and weaknesses, and client-level and systems-level barriers to the client meeting his/her needs. An assessment can be conducted solely by the case manager, with the input of other team members involved in the client's care, and/or engaging the client to provide a self-assessment of need and functioning.

The content of the assessment is often outlined by the intake/assessment forms used by the agency, which specify the various areas for data collection and assessment. The more comprehensive this process is, the more able the case manager is to systemically evaluate the client's needs and to formulate goals.

Three standards are included in this case management phase.

[14] These numerals refer to the specific Standard number of the "Case Management Standards" ratified by the Greater Balitmore HIV Health Services Planning Council, October 1998.

Summary of findings

A total of 232 clients (50% of total number of reviewed records) had a documented needs assessment completed after January 1, 2001. Case managers consistently completed needs assessments, with 81% meeting this standard. Six charts identified limited or one-time intervention. Of these 67% conducted a mini-assessment specific to the client identified problem.

Compliance with each of the four standards within Phase 3 are presented below.

	EMA Case Management Standard	Percent of reviewed charts meeting standard
2.3a	Case manager shall complete a comprehensive written psychosocial needs assessment for each client within 30 days or by the conclusion of the 3rd case management visit, whichever comes first. The needs assessment shall include a medical/-psychosocial history and shall be included in the client record. Required for **intensive** and **intermediate/periodic** case management.	**81%** **(n=226)** Note: 6 charts were excluded from analysis; these clients were identified as receiving services at the limited or one-time case management level. See table below for areas included in the assessment.
2.3a	Case manager shall ensure that client chart contains written indication that current needs have been discussed and/or identified at time of needs assessment (3.a). Case manager should review the listed areas of consumer/client needs when performing needs assessment (3.a).	**74%** (n=226) Note: 6 charts were excluded from analysis; these clients were identified as receiving services at the limited or one-time case management level.
2.3b	Agency should ensure that a mini-assessment specific to the client-identified problem is completed for any individual requesting **limited/one time** intervention (3).	**67%** (n=226) Note: Only 6 charts identified receiving services at the limited or one-time case management level in standard 3.3.a, above, were included in this assessment.

The EMA Case Management Standards (2.3a) outline the areas to be included in the assessment. Table 35 shows the proportion of client assessments that included the specified area. The client's living situation was the most common area included (76% of assessments) with spirituality issues being included in only 14% of assessments. Given the high rate of substance use in the Baltimore EMA, it is encouraging that 70% of the assessments addressed this issue.

Table 35. areas included in case management needs assessment

Area of assessment	% of needs assessment documenting outlined area
Living situation	76%
Substance abuse history	70%
Psychiatric/mental health history	68%
Recreational/social activities	68%
Medical history	67%
Family composition	66%
Financial status/entitlements	66%
Presenting problem	66%
Social/community supports	66%
Employment history/status	62%
Health insurance/prescription plans	60%
Current health status	59%
Health symptoms	54%
Current medications	53%
Awareness of safer sex practices	52%
Emotional/behavioral issues	50%
Nutritional status	32%
Legal history	30%
Physical/sexual abuse history	18%
Sexuality issues	17%
Spirituality issues	14%

Phase 4: Development of Client Plan of Care

Purpose and key activities of case management phase

Following the client's intake and assessment, the case manager, with the participation of the client formulates an individualized plan of care, or service plan. The plan consists of the articulation of specific goals and objectives, which should be written in a time-phased format. In developing the plan, the case manager uses his/her knowledge of the community's resources and agency linkages that will be used to meet the identified needs that are articulated as goals in the plan. The format of the plan should also include outcome criteria that will be used to assess the achievement of the case plan goals.

By developing the plan with the client's active participation, the plan should be client-centered and reflective of the client's expectations and choices. The client, or his/her agent, signs the plan to indicate his/her agreement with the established goals as well as the roles of the client and case manager in the implementation of the plan.

Four standards are included in this case management phase.

Summary of findings

A total of 235 clients (50% of total number of reviewed records) were determined to be in this phase of case management during the review period. Nearly three-quarters of the reviewed charts met the standards relating to the development of the care plan; however, only 65% of charts had care plans that were signed and dated by both the client and case manager.

Compliance with each of the four standards within Phase 4 are presented below.

	EMA Case Management Standard	Percent of reviewed charts meeting standard
2.4a	Case manager shall, with active participation of client, identifying which needs are to be addressed through the development of goals and objectives. Establish time frames for meeting goals and resolving the problem. Incorporate written objectives and goals into the plan of care, which is a permanent part of the client chart.	73% (n=230) Note: 5 charts were excluded from analysis; these clients were identified as receiving services at the limited or one-time case management level. A total of 230 charts were considered in this analysis.
2.4a	Development of the plan of care should be completed by the 3rd case management visit or within 30 working days from the date of assignment to a case manager.	74% (n=230) Note: 5 charts were excluded from analysis; these clients were identified as receiving services at the limited or one-time case management level. A total of 230 charts were considered in this analysis.
2.4b	Agency, together with client, shall identify appropriate resources needed to attain stated goals and objectives. Resources shall be written into plan of care.	74% (n=230) Note: 5 charts were excluded from analysis; these clients were identified as receiving services at the limited or one-time case management level. A total of 230 charts were considered in this analysis.
2.4c	All plans of care should be signed and dated by both the client and case manager.	65% (n=230) Note: 5 charts were excluded from analysis; these clients were identified as receiving services at the limited or one-time case management level. A total of 230 charts were considered in this analysis.

PHASE 5: IMPLEMENTATION AND COORDINATION OF CLIENT PLAN

Purpose and key activities of case management phase

Following the development of a written plan, the case manager is responsible for the coordination of the implementation of the plan. Often, this consists of frequent contact

with the client and other service providers to ensure that identified services are received and that these services meet the identified needs. Because many of the needed services are provided by other agencies, many of which require their own application process, the case manager needs to make formal referrals for these services and work with the client in completing these intake and application processes. These contacts and referrals should be documented, with their outcomes noted either on the case plan and/or in progress notes.

During this phase, the case manager is expected to use his/her professional skills to promote the client's self-sufficiency and own personal capacity-building goals while balancing the need to advocate on behalf of the client and providing assistance with completing referrals and applications.

Two standards are included in this case management phase.

Summary of findings

All of the client files (n=466) were included in the review of this phase of case management. Three-quarters (75%) of the reviewed charts were determined to either fully or partially met the standard relating to documentation of referrals and outcomes.

Compliance with each of the four standards within Phase 5 are presented below.

	EMA Case Management Standard	Percent of reviewed charts meeting standard
2.5a	Case manager shall proactively attempt to contact client after the development of the plan to implement those parts that were not executed at the time of plan development. Plan will establish priorities among the identified needs.	64%
2.5c	Case manager shall document in writing all referrals and outcomes initiated and/or completed as they relate to the plan of care. Any corresponding actions initiated by the client/other identified people and the outcomes resulting from these actions shall be incorporated into the client record.	43% of the reviewed charts **FULLY** met this standard. 32% of the reviewed charts **PARTIALLY** met this standard. 25% of the reviewed charts **DID NOT** meet this standard. *Overall, 75% of charts either fully or partially met this standard.*

PHASE 6: MONITORING THE CLIENT PLAN

Purpose and key activities of case management phase

The monitoring of the implementation of the client plan complements the implementation phased of case management. The case manager is in frequent contact with the client to determine the status of the implementation of the client plan and to determine when additional advocacy and intervention is needed to obtain the identified

services. The frequency of monitoring is determined by the level of case management identified at the time of the intake and assessment. During the monitoring phase, the case manager continues to document his/her actions.

As specified by the EMA case management standards, if the case manager cannot successfully make contact with the client, then he/she should take specific actions to locate the client; and if unsuccessful in contacting the client, then the case manager should take specific actions to close the case management file.

Five standards are included in this case management phase.

Summary of findings

All of the client files (n=466) were included in this review of this phase of case management. Approximately two-thirds of the charts documented compliance of contact with the client according to the level of case management. Follow up with clients was extremely low. Only 26% of cases were referred for case finding when clients could not be contacted and even fewer were transferred to "inactive" status after 90 days without contact. Only 21% of charts were officially closed. These findings correspond to the results of the agency survey which found that many agencies do not have policies related to client monitoring.

Compliance with each of the four standards within Phase 6 are presented below.

<table>
<tr><th></th><th>EMA Case Management Standard</th><th>Percent of reviewed charts meeting standard</th></tr>
<tr><td>2.6a</td><td>Documentation of the monitoring process shall be recorded in the client record. Monitoring shall occur at a minimum of the following:
Intensive case management:
A minimum of 1 contact per month
1 face-to-face contact every 6 months

Intermediate/periodic case management
Case manager initiates a minimum of 1 contact every 3 months
1 face-to-face contact every 6 months

Limited intervention
Case manager is involved in no more than 2 contacts limited to particular issues.

<table>
<tr><th>Level of case management</th><th>Number (% of total)</th></tr>
<tr><td>Intensive</td><td>160 (34%)</td></tr>
<tr><td>Intermediate/Periodic</td><td>156 (33%)</td></tr>
<tr><td>Limited/One-time</td><td>26 (6%)</td></tr>
<tr><td>Missing/Not documented</td><td>124 (27%)</td></tr>
<tr><td>Total</td><td>466 (100%)</td></tr>
</table>
</td><td>66%</td></tr>
</table>

2.6a	If a client cannot be located after several attempts to reach by telephone and/or letter, for 2 months, then a referral is made to case finding to assist in locating the client.	**26%** (n=124) Note: 342 charts were excluded from analysis; these clients were identified as having an appropriate level of contact and referral was not required. A total of 124 charts were considered in this analysis.
2.6a	If the client cannot be located within 90 days, the case management record is moved to inactive status.	**12%** (n=69) Note: 397 charts were excluded from analysis; these clients were identified as having an appropriate level of contact and referral was not required (standard 3.6.b, above) or were located within the 90 days and moving the record to an inactive status was not required. A total of 69 charts were considered in this analysis.
2.6a	At end of year, if there is no contact, then the case management record is closed (for intensive and intermediate).	**21%** (n=52) Note: 414 charts were excluded from analysis; these clients were identified as having an appropriate level of contact and referral was not required (standard 3.6.b, above), were located within the 90 days and moving the record to an inactive status was not required, (standard 3.6.d, above), or contact was made with the client and closure was not required. A total of 52 charts were considered in this analysis.
2.6c	Case manager shall provide written documentation (progress notes) of any difficulties encountered in achieving the goals and objectives and provide written strategies for resolving these difficulties.	**61%**

PHASE 7: REEVALUATION OF PLAN OF CARE

Purpose and key activities of case management phase

The client plan of care is routinely reassessed to determine what progress has been made in achieving the case plan goals and to identify any new needs or problems. While the case manager is making this assessment throughout the implementation and monitoring phases, a formal reassessment is completed at a minimum of every six months. The reevaluation

can be done by the case manager, or by another agency staff person. As with the initial assessment, the client is involved in this process and in the formulation of any new goals. If all of the client's case plan goals are met and no new needs identified, then the client may be discharged from case management services.

Two standards are included in this case management phase.

Summary of findings

Only case management files which had been opened for longer than six months were considered for review (n=366) of these, only 37% of charts had a documented reevaluation of the plan of care (Standard 2.7a). Of the 136 charts that were reevaluated and the needs were determined to have changed, 96% of these met the subsequent standard specifying the development of new goals and objectives based on the re-assessment of client needs. The case manager, with a few instances of peer review or supervisor reassessment, almost always conducted the reassessment.

Compliance with each of the two standards within Phase 7 are presented below.

	EMA Case Management Standard	Percent of reviewed charts meeting standard
2.7a	Each agency shall assess the client records a minimum of every 6 months to determine the client's status and progress and whether any revision is needed in the care plan or in the provision of services. Record review in the progress notes. Record review may be done by the case manager, supervisor, peer review, formal audit, etc.	37% **(n=366)** Note: 100 charts were excluded from analysis because they had been active case management clients for less than 6 months, and not required to be evaluated under the standard. A total of 366 charts were considered in this analysis.
7.b	The case manager shall develop, with the active participation of the client, new goals and objectives if the needs have changed since the previous needs assessment.	**96%** (n=117) Note: Of the 136 charts which had been reassessed, 19 were excluded from analysis because the re-assessment found that the client's needs had not changed, and therefore, the development of new goals and objectives was not required. A total of 117 charts were considered in this analysis.

PHASE 8: CLOSURE

Purpose and key activities of case management phase

Closure of the case management chart may occur for a number of reasons, including the successful completion of the client's plan of care, client death, relocation, or request. Additionally, if the agency is not able to contact the client as outlined in the monitoring

phase (Phase 6), then the chart should be closed. Whenever possible, the case manager should prepare the client for termination and make appropriate referrals to ensure for continuity of services. The case manager should adhere to the agency's policies regarding termination and case closure and document these steps.

Two standards are included in this case management phase.

Summary of findings

All of the client files (n=466) were included in the review of this phase of case management. Only 8% of client charts (n=38) were closed during CY 2001, with client death being the most frequent reason for closure [Table 36]. The mean length of service for these 38 clients was 32.5 months (min=2, max=117).

TABLE 36. REASON FOR CLOSURE OF CASE MANAGEMENT FILE

Reason for closure n=38	# (% of column)
Client death	12 (32%)
Lack of client contact	8 (21%)
At the request of the agency	6 (16%)
At the request of the client	4 (11%)
Client relocation	1 (3%)
Missing/not documented	7 (18%)

Only 8% of client charts were closed during CY 2001. However, findings relating to client monitoring (Phase 6) indicate that case managers are not maintaining the specified frequency of contact with clients, nor are they appropriately responding to this lack of client contact, which includes termination of case management services and closure of charts.

Compliance with each of the two standards within Phase 8 are presented below.

	EMA Case Management Standard	Percent of reviewed charts meeting standard
2.8a	Prior to closure (with the exception of death), the agency shall attempt to inform the client of the re-entry requirements into the system, and make explicit what case closing means to the client.	**50%** (n=38)
2.8b	The agency shall close a client file according to the procedures established by the agency.	**74%** (n=38)

Section 5. Client-level case management outcomes

The QIP process also sought to determine what benefits the clients received from their case management services. Since one of the primary functions of case management services is to meet identified unmet client needs, this outcome of case management services was assessed in six areas: 1) income assistance; 2) health insurance: 3) housing; 4) primary health care provider; 5) substance abuse treatment services; and 6) emotional counseling.

Adapting a case management outcomes evaluation methodology described by Mitchell H. Katz, MD and colleagues[15], QIP reviewers were asked to determine whether the:

1. Client's needs assessment identified a need in each of the six areas;
2. Client's case plan contained a goal to meet this identified need;
3. Client's record contained documentation of activities (e.g., progress notes or updated case plan) to meet this goal; and
4. Identified need was met through the provision of case management services.

Definitions of met and unmet need used for outcome analysis

NEED	DEFINITION OF "UNMET "NEED	DEFINITION OF "MET" NEED
Income Assistance	• Being unemployed; and/or • Not receiving any public assistance	• Being employed and/or • Receiving some public assistance
Health Insurance	• Having no health insurance; and/or • Having inadequate insurance to meet needs	• Having a form of health insurance and/or • Having insurance to meet unmet need
Housing	• Being unstably housed; • Living in shelter, SRO, doubled-up; • Living in situation other than one's own house, apt., supported living	• Being stably housed • Living in one's own house, apt., supported living
Primary Health Care Provider	• Not being able to identify primary health care provider/agency for HIV and other health care needs	• Being able to identify a primary health care provider/agency for HIV and other health care needs; • Being able to report current CD_4 count, viral load, treatment regimen

[15] Katz, MH, et. al., "Effect of Case Management on Unmet Needs and Utilization of Medical Care and Medications among HIV-Infected Persons" Annals of Internal Medicine 2001;135:557-565.

Substance Abuse Treatment Services	• Self reported drug or alcohol use and/or dependence during period before intake; • Use of illicit/prescription drugs known to cause dependence; • Use of more drugs than intended; • Present of emotional/psychiatric problem associated with drug use	• Having received professional substance abuse services or participating in a self-help group
Emotional Counseling	• Self-reported	• Having seen a mental health provider, attended a support group or seen a spiritual provider

Summary of client charts with current case plan included in outcomes analysis, by gender and race/ethnicity

	Number of charts reviewed in QIP	Number of charts with case plans (% of total of QIP)
All Clients	466	288 (62%)
Gender		
Female	163	86 (53%)
Male	287	196 (68%)
Transgender	2	1 (50%)
Missing/Not documented	14	5 (36%)
Race		
African-American	367	215 (59%)
White	50	41 (82%)
Hispanic	8	5 63%)
Asian/Pacific-Islander	4	3 (75%)
Native American	2	2 (100%)
Other	9	8 (89%)
Missing/Not documented	26	14 (54%)

For purposes of this review, only records that contained a current case plan (n = 288) were included, representing 62% of the total records. Income assistance was the most common unmet need identified for clients with a defined case plan (48%) followed closely by housing (44%). Requiring a primary health care provider was the least frequently identified unmet need (29%), yet it was the most commonly need met. Ninety percent of clients who needed a primary health care provider were linked to care during the review

period. In contrast, only 35% of clients in need of income assistance had this need met[16]. Case management services were highly effective in meeting the need for substance abuse treatment services (63%) and emotional counseling (57%). Given the difficulty in securing housing, it is not surprising that case management services were substantially less effective in addressing the clients' needs for housing (39%).

[16] In some instances case management activities were being undertaken but had not successfully met the need by the end of the review period.

Table 37 summarizes data related to client-level case management outcomes. Tables 38-49 delineate results for each of the six service needs and presents data by gender and race/ethnicity.

Table 37. summary of client-level case management outcomes

Area of client need	#/% of charts with identified unmet need	# (%) of charts with identified unmet need which have a care plan goal established to meet need	# (%) of charts with identified unmet need which have documented case management activities to meet need	# (%) of charts with identified unmet need which have successfully met the identified need during the review period
Income assistance	137 (48%)	108 (79%)	92 (67%)	48 (35%)
Health insurance	123 (43%)	109 (89%)	104 (85%)	75 (61%)
Primary health care provider	82 (29%)	75 (91%)	76 (93%)	74 (90%)
Housing	127 (44%)	106 (83%)	98 (77%)	49 (39%)
Substance abuse treatment services	88 (31%)	74 (84%)	69 (78%)	55 (63%)
Emotional counseling	97 (34%)	90 (93%)	78 (80%)	55 (57%)

Income Assistance

Of the 288 clients, 137 (48%) identified a need for income assistance, including half of the men and 44% of women. Specific goals and activities to address the need were more often documented for women. Regardless of gender, case management activities were not consistently effective in meeting this need. Income assistance was successfully addressed for 32% of all women. For men, the results were marginally improved with 36% successfully addressing this need.

Over one-half (52%) of African-Americans identified a need for income assistance. Of the 111 African-Americans needing assistance, 76% had a goal established in the care plan with 37% ultimately meeting the need. One-third of Caucasians identified the need for income assistance. While 93% had a goal established, only 29% ultimately achieved this goal.

Table 38. income assistance client-level case management outcomes by gender

	Female	Male	Transgender	Missing/ Not doc	Total
Was unmet need identified?	38 (44%)	97 (50%)	-	2 (40%)	137 (48%)
Was goal established in care plan to address need?	31 (82%)	75 (77%)	-	2 (100%)	108 (79%)
Are there case management activities documented to address the need?	28 (74%)	62 (64%)	-	2 (100%)	92 (68%)
Was the identified need met?	12 (32%)	35 (36%)	-	1 (50%)	48 (35%)

Table 39. income assistance client-level case management outcomes by race

	African-American	White	Hispanic	Asian/Pacific Islander	Native American	Other	Missing/ Not doc	Total
Was unmet need identified?	111 (52%)	14 (34%)	2 (40%)	--	1 (50%)	4 (50%)	5 (36%)	137 (48%)
Was goal established in care plan to address need?	84 (76%)	13 (93%)	2 (50%)	--	1 (100%)	4 (100%)	4 (80%)	108 (79%)
Are there case management activities documented to address the need?	74 (67%)	11 (79%)	1 (50%)	--	1 (100%)	2 (50%)	4 (80%)	92 (68%)
Was the identified need met?	41 (37%)	4 (29%)	0 (%)	--	0 (0%)	2 (50%)	1 (20%)	48 (35%)

Health Insurance

The need for health insurance was the third most commonly identified need. A total of 123 clients did not have adequate health insurance, including 46% of men and 36% of women. Goals and specific case management activities were consistently documented for both men and women. Men were slightly more likely to have the need met during the review period.

Compared to other racial groups, African-Americans were less likely to have health insurance identified as an unmet need . Once identified, however, goals and activities were consistently documented, resulting in slightly more than half having this need met (54%). While the sample size for Hispanics was small (n=4), 80% identified inadequate health insurance as a need and 100% ultimately had this need met. Data are similar for Asian/Pacific Islanders and Native Americans. Documentation of case management activities (e.g., establishment of a goal, and documentation of activities) were more consistently noted for this service need as compared to the five other service needs assessed.

Table 40. health insurance client-level case management outcomes by gender

	Female	Male	Transgender	Missing/ Not doc	Total
Was unmet need identified?	31 (36%)	90 (46%)	-	2 (40%)	123 (43%)
Was goal established in care plan to address need?	26 (84%)	81 (90%)	-	2 (100%)	109 (91%)
Are there case management activities documented to address the need?	29 (94%)	73 (81%)	-	2 (100%)	104 (87%)
Was the identified need met?	18 (58%)	55 (61%)	-	2 (100%)	75 (61%)

Table 41. health insurance client-level case management outcomes by race/ethnicity

	African-American	White	Hispanic	Asian/Pacific Islander	Native American	Other	Missing/ Not doc	Total
Was unmet need identified?	84 (39%)	19 (46%)	4 (80%)	1 (34%)	1 (50%)	6 (75%)	8 (57%)	123 (43%)
Was goal established in care plan to address need?	72 (86%)	17 (90%)	4 (100%)	1 (100%)	1 (100%)	6 (100%)	8 (100%)	109 (91%)
Are there case management activities documented to address the need?	68 (81%)	17 (90%)	4 (100%)	1 (100%)	1 (100%)	4 (67%)	7 (88%)	104 (87%)
Was the identified need met?	45 (54%)	11 (58%)	4 (100%)	1 (100%)	1 (100%)	6 (100%)	7 (88%)	75 (61%)

Primary Health Care Provider

The need for a primary health care provider was identified for only 29% of the 288 clients for whom a care plan was established. Of these, the percentages of men and women were equally represented. Regardless of gender and race/ethnicity, goals and case management activities were consistently documented with exceedingly high success rates reported. These results suggest that case management services are able to meet the primary goal of the Ryan White CARE Act to facilitate access to primary health care services.

Table 42. primary health care provider client-level case management outcomes by gender

	Female	Male	Transgender	Missing/ Not doc	Total
Was unmet need identified?	24 (28%)	55 (28%)	-	3 (60%)	82 (29%)
Was goal established in care plan to address need?	24 (86%)	49 (89%)	-	3 (100%)	75 (94%)
Are there case management activities documented to address the need?	24 (100%)	50 (91%)	-	3 (100%)	76 (94%)
Was the identified need met?	22 (92%)	50 (91%)	-	3 (100%)	74 (91%)

Table 43. primary health care provider client-level case management outcomes by race/ethnicity

	African-American	White	Hispanic	Asian/Pacific Islander	Native American	Other	Missing/ Not doc	Total
Was unmet need identified?	56 (26%)	9 (22%)	2 (40%)	1 (34%)	1 (50%)	5 (63%)	8 (57%)	82 (29%)
Was goal established in care plan to address need?	53 (95%)	9 (100%)	0 (0%)	1 (100%)	0 (0%)	5 (100%)	8 (100%)	75 (94%)
Are there case management activities documented to address the need?	53 (95%)	9 (100%)	1 (50%)	1 (100%)	1 (100%)	5 (100%)	7 (88%)	77 (94%)
Was the identified need met?	51 (91%)	9 (100%)	1 (50%)	1 (100%)	1 (100%)	5 (100%)	7 (88%)	74 (91%)

Housing

Housing was identified as the second most commonly identified need. A total of 127 clients did not have stable housing, including 45% of men and 42% of women. While goals and case management activities were slightly more often delineated for women than men, housing was more often successfully secured for men (42% vs. 28%).

African-Americans had the greatest unmet need for housing and their success in meeting this need was slightly less than the total group's. Fifty one percent of African-Americans identified a need for housing compared to 22% for Caucasians. Documented case management activities were comparable across racial groups.

Table 44. housing client-level case management outcomes by gender

	Female	Male	Transgender	Missing/ Not doc	Total
Was unmet need identified?	36 (42%)	89 (45%)	-	2 (40%)	127 (44%)
Was goal established in care plan to address need?	33 (92%)	71 (80%)	-	2 (100%)	106 (85%)
Are there case management activities documented to address the need?	30 (83%)	66 (74%)	-	2 (100%)	98 (78%)
Was the identified need met?	10 (28%)	37 (42%)	-	2 (100%)	49 (39%)

Table 45. housing client-level case management outcomes by race/ethnicity

	African-American	White	Hispanic	Asian/Pacific Islander	Native American	Other	Missing/ Not doc	Total
Was unmet need identified?	110 (51%)	9 (22%)	--	--	--	3 (38%)	5 (38%)	127 (44%)
Was goal established in care plan to address need?	89 (80%)	9 (100%)	--	--	--	3 (100%)	5 (100%)	106 (85%)
Are there case management activities documented to address the need?	85 (77%)	7 (78%)	--	--	--	2 (67%)	4 (80%)	98 (78%)
Was the identified need met?	42 (38%)	4 (44%)	--	--	--	1 (33%)	2 (40%)	49 (39%)

Substance Abuse Treatment Services

Given the high level of substance use documented in the Baltimore EMA, it was surprising to note that only 31% of clients with a care plan had an identified need for substance abuse treatment services. Of the 88 clients documenting a need for treatment, the percentage of men and women were equally represented. Goals were consistently documented and case management activities delineated. Women were slightly more likely to have had the need met with 62% accessing services, compared to 59% for men. Overall, 63% of all clients with an identified need for substance abuse treatment services ultimately received care.

One-third of African-Americans and 15% of Caucasians identified a need for substance abuse treatment. Significantly fewer African-Americans had the need ultimately met compared to Caucasians (62% vs. 83%).

Table 46. substance abuse treatment services client-level case management outcomes by gender

	Female	Male	Transgender	Missing/ Not doc	Total
Was unmet need identified?	26 (30%)	61 (31%)	-	1 (20%)	88 (31%)
Was goal established in care plan to address need?	21 (81%)	53 (87%)	-	1 (100%)	74 (84%)
Are there case management activities documented to address the need?	20 (77%)	49 (80%)	-	1 (100%)	69 (78%)
Was the identified need met?	16 (62%)	39 (59%)	-	1 (100%)	55 (63%)

Table 47. substance abuse treatment services client-level case management outcomes by race/ethnicity

	African-American	White	Hispanic	Asian/Pacific Islander	Native American	Other	Missing/ Not doc	Total
Was unmet need identified?	72 (34%)	6 (15%)	--	--	1 (50%)	2 (25%)	7 (50%)	88 (31%)
Was goal established in care plan to address need?	62 (86%)	5 (83%)	--	--	1 (100%)	2 (100%)	5 (71%)	74 (84%)
Are there case management activities documented to address the need?	58 (81%)	5 (83%)	--	--	0 (0%)	2 (100%)	5 (71%)	69 (78%)
Was the identified need met?	45 (63%)	5 (83%)	--	--	0 (0%)	2 (100%)	4 (57%)	55 (63%)

Emotional Counseling

The need for emotional counseling was identified in 34% of the clients. Forty three percent of women had this need identified compared to 30% of men. Regardless of gender, goals were consistently outlined and case management activities documented. The need for emotional counseling was met for slightly more than half of the clients, regardless of gender.

Approximately one-third of all clients, regardless of race/ethnicity identified emotional counseling as an unmet need. While goals were consistently established for all groups, activities to address the need were significantly lower among Caucasians and ultimately reflected in the successful achievement of the goal. The needs were met for 57% of African-Americans and 100% for other racial/ethnic groups. The success rate for Caucasians was limited to 36%.

Table 48. emotional counseling client-level case management outcomes by gender

	Female	Male	Transgender	Missing/ Not doc	Total
Was unmet need identified?	37 (43%)	58 (30%)	-	2 (40%)	97 (34%)
Was goal established in care plan to address need?	35 (95%)	54 (93%)	-	2 (100%)	90 (96%)
Are there case management activities documented to address the need?	30 (81%)	46 (79%)	-	2 (100%)	78 (82%)
Was the identified need met?	20 (54%)	34 (59%)	-	2 (100%)	55 (57%)

Table 49. emotional counseling client-level case management outcomes by race/ethnicity

	African-American	White	Hispanic	Asian/Pacific Islander	Native American	Other	Missing/ Not doc	Total
Was unmet need identified?	70 (33%)	14 (34%)	--	1 (34%)	1 (50%)	3 (38%)	8 (57%)	97 (34%)
Was goal established in care plan to address need?	67 (96%)	12 (86%)	--	1 (100%)	1 (100%)	3 (100%)	7 (88%)	90 (96%)
Are there case management activities documented to address the need?	57 (81%)	8 (57%)	--	1 (100%)	1 (100%)	3 (100%)	8 (100%)	78 (82%)
Was the identified need met?	40 (57%)	5 (36%)	--	1 (100%)	1 (100%)	3 (100%)	6 (75%)	55 (59%)

Section 6. Agency-Level assessment of compliance with EMA case management standards

As part of the QIP process, case management agencies were asked to complete a 5 page-survey (See Appendices for a copy of the instrument). The purpose of this survey was to document the self-reported compliance with the EMA's Case Management Standards pertaining to agency policies and procedures. All data presented is self-reported by the surveyed agencies and the QIP process did not verify the agencies' responses.

Table 50 lists the services directly provided by the case management agencies and those provided through referral agreements. The 17 case management agencies provide a large number of other services to clients. They range from primary ambulatory care to ancillary and supportive services, such as transportation and direct emergency assistance. They also indicate having access to a wide array of services through referral agreements. Legal services is the only service for which respondents are more likely to provide through referral than directly.

Table 50. services provided directly by case management agencies or through referral agreements

Service (n=17)	% which provide service directly	% with referral agreements for service
Case Management	100%	6%
Client Advocacy	88%	0%
Ambulatory Health Care	82%	18%
Outreach	82%	12%
Transportation	82%	24%
Direct Emergency Assistance	76%	18%
Viral Load Testing	71%	24%
Mental Health Services	65%	18%
Substance Abuse Treatment	65%	47%
Counseling	65%	18%
Housing Assistance	65%	41%
Food/Nutrition	59%	59%
Dental Care	47%	47%
Co-morbidity Services	41%	12%
Legal Services	24%	53%
Buddy/Companion	18%	29%
Enriched Life Skills	18%	12%
Other: OB/GYN	12%	
Other: HIV/CTS	12%	6%
Other: Adherence	12%	
Other: Pharmacy	6%	6%
Other: Capacity Building	6%	
Other: Ophthalmology		12%
Other: Dermatology		6%
Other: Laboratory		6%

Licensure

While respondents indicate that their staff are all appropriately licensed, 24% of the agencies report that they are not in compliance with the standard relating to agency licensure.

EMA Case Management Standard	Percent of agencies reporting that they are in compliance with standard
Is the agency licensed by an appropriate body? (Standard 3.0a)	**76%**
Where applicable, do staff have licenses that are current and appropriate for providing case management services? (3.0c)	**100%**

Training and Supervision

Responding agencies indicate a high degree of compliance with standards relating to staff training and supervision. As part of the survey process, agencies were asked to describe what mechanisms are used to regularly update staff on service availability. All agencies indicated a system was in place to update staff on service availability. The most frequently cited method was routine staff meetings.. Other methods cited include attendance of staff at conference and workshops, distribution of materials and publications among staff, formalized in-house training program, outreach and networking with other agencies, and formalized training program provided by an external agency.

EMA Case Management Standard	Percent of agencies reporting that they are in compliance with standard
Are case management services provided directly by, or under supervision of, or in consultation with a licensed social worker and/or registered nurse case manager? (4.0a)	**94%**
Does the agency maintain documentation for each staff person of all in-service and/or specialized training, given or taken, on pertinent topics related to HIV/AIDS? (4.0b)	**94%**
Does the agency have written policies that encourage and allow continuing education and professional development opportunities to be pursued on a regular basis? (4.0c)	**94%**
Does the agency have a system that regularly updates the staff of available services for people living with HIV/AIDS? (4.0d)	**100%**

Practice

Agencies report a wide range of compliance with standards relating to case management practice. While they report having policies and procedures for many of the initial phases of case management (i.e., eligibility, assessment, development of a client plan of care), fewer policies and procedures are in place related to monitoring and closure of inactive cases.

The chart review process found that standards relating to client monitoring and closure of inactive cases were less likely to be in compliance with the case management standards

than the standards relating to the earlier phases of case management. This suggests that there is a correlation between an agency having a policy and the actual case management practice.

EMA Case Management Standard Agencies must have written policies and procedures regarding:	Percent of agencies reporting that they are in compliance with standard
a. Eligibility for service (2.1)	**94%**
b. Determining level of case management services (1.0)	**76%**
c. Timeframe for addressing emergency needs identified during Intake (2.2b)	**53%**
d. Timeframe for scheduling of first case management appointment (2.2c)	**82%**
e. Timeframe for completion of written psychosocial needs assessment (2.3c)	**88%**
f. Development of client plan of care (2.4a)	**88%**
g. Timeframe for the development of client plan of care (2.4a)	**88%**
h. Review of plan of care with client and signing and dating of plan of care by both case manager and client (2.4a/2.4c)	**88%**
i. Documentation of referrals and outcomes (2.5c)	**71%**
j. Frequency of case manager-initiated contacts with clients receiving case management services (2.6a)	**76%**
k. Timeframe for re-evaluation of client plan of care (2.7a)	**82%**
l. Timeframe for referral of clients lost to follow-up for case finding assistance (2.6a)	**47%**
m. Time frame for moving client file to inactive status (2.6a)	**65%**
n. Timeframe for closure of case management file (2.6a)	**59%**
o. Informing client regarding termination of case management services and requirements re-entry for case management services (5.0g/2.8a)	**76%**
p. Closure of client file (2.8)	**59%**

MAINTENANCE OF RECORDS

Agencies report a higher degree of compliance with policies relating to storage of adult records than those relating to storage of children's records.

EMA Case Management Standard	Percent of agencies reporting that they are in compliance with standard
Are records for adult clients (over 18 years) kept for a minimum of ten years after last record entry? (2.8c)	**88%** (n = 16)
Are records for children clients (over 19 years) archived until the child reaches the age of 24 or six years after death, if sooner? (2.8c)	66% (n = 12)

CONSUMER/CLIENT RIGHTS AND RESPONSIBILITIES

Agencies indicate a high degree of compliance with policies and procedures relating to confidentiality, eligibility, client rights and responsibilities, and grievance, but fewer have

policies relating to termination and case closure and in having clients document their receipt of these client-focused policies.

EMA Case Management Standard	Percent of agencies reporting that they are in compliance with standard
Does the agency have a written policy on confidentiality? (5.0a)	100%
Does the agency routinely provide to clients copies of eligibility criteria and services available? (5.0b)	88%
Does the agency routinely ask clients to sign a written consent of the release of information? (5.0c)	100%
Does the agency have a written grievance procedure? (5.0e)	100%
Does the agency have a statement of client rights as well as responsibilities or agency expectations of each client? (5.0f)	100%
Does the agency have a statement that outlines the process for both voluntary and involuntary disengagement from services? (5.0g)	71%
Does the agency routinely explain to clients existing agency policies and procedures regarding confidentiality, grievance, eligibility and service? (5.0b)	94%
Does the agency routinely ask clients to sign a statement and include this statement in the client record verifying that these policies and procedures have been explained? (5.0b)	59%

QUALITY ASSURANCE

All agencies report having a process for clients to evaluate the agency's staff and services. Almost all of the respondents (94%) indicate using a client satisfaction survey, often referring to the state's AIDS Administration or the EMA's Planning Council's survey or the agency's own client survey. Only 41% indicated having a consumer advisory board. Other methods used also included suggestion boxes placed at the agency and consumer representation on the agency's board. Not all agencies report having a quality assurance plan in place.

EMA Case Management Standard	Percent of agencies reporting that they are in compliance with standard
Does the agency have a quality assurance plan to monitor both appropriateness and effectiveness of case management services? (6.0)	88%
Does the agency have a process for clients to evaluate the agency, staff and services? (6.0g)	100%

Section 7. Summary

The QIP process provided a systematic review of compliance to the EMA's Standards of Care for 100% of case management vendors (n=17) receiving Title I funds during FY 2002. A total of 466 case management charts were reviewed, representing approximately one-third of Title I case management clients. The charts reviewed reflected the epidemiological data of the defined service area in respect to gender, race/ethnicity and disease status. With a few exceptions, many of the standards were consistently met and data clearly show that many clients have been retained in care for greater than two years. In respect to the specific standards of care, several key points should be highlighted:

- Psychosocial assessments were consistently completed (80%) as part of the intake process.
- A history of substance abuse was assessed for 70% of clients for which an assessment was completed.
- Clients in need of appointments with medical providers (82%) were linked to care.
- Nearly three-quarters of clients had a plan of care developed.
- Referrals were fully documented for 43% of clients with an additional 32% with limited documentation.
- When re-evaluation of the plan of care was conducted, new goals and objectives were established for nearly 100% of clients.
- Twenty-seven percent of client who did not have insurance coverage at their first entry in the review period obtained insurance coverage during the review period.
- All agencies report having a process for clients to evaluate the agency's staff and assurance plan.

Several key findings were identified and include the following:

- Client eligibility continues to be an issue that vendors struggle with. Many clients were noted to have multiple forms of insurance, reside in areas outside of the EMA or otherwise lacked documented eligibility information. Agencies, however, self-report a high degree of compliance relating to client eligibility and screening.
- Many of the case management charts did not contain complete client data and medical-related data was not routinely collected or updated.
- Consent to receive services was documented in slightly more than half of the adult clients and only in 5% infants and children.
- When limited or one-time case management services were provided, mini-assessments specific to the identified problem were conducted only 67% of the time.
- Care plans were signed and dated by both the case manager and the client 65% of the time.
- While 75% of referrals had some form of documentation, 25% of the charts provided no information related to the referral or the outcome.
- Only 26% of cases were referred for case finding when the level of contact did not correspond to the documented level of case management service. A limited

number of clients were transferred to an "inactive" status after 90 days without any contact. Only 21% of the charts were officially closed. These findings correspond to the results of the agency survey which found that many agencies do not have policies related to the frequency of client contact and monitoring.

- While the Standard indicates that client records should be assessed every six months, re-evaluation occurred for only 37% of the clients.

Overall, agencies self-report a high degree of compliance with Standards relating to agency policies and procedures and case management practice. A lower degree of compliance was reported for Standards related to monitoring, reassessment and closure of client files. These self-reported findings were supported by data obtained via chart abstraction.

As a group, the case management vendors have successfully linked clients to care, particularly for primary medical providers, substance abuse treatment services and emotional support services. Health insurance was secured for 61% of clients who lacked adequate coverage. These data indicate case management services support the intent and goal of the Ryan White CARE Act to link and retain clients in care.

Appendices

1. Case Management Services Client Chart Abstraction Instrument, January 2002
2. Case Management Services Agency Survey, January 2002
3. Case Management Standards, Greater Baltimore HIV Health Services Planning Council, Ratified 1988

BCHD Quality Improvement Project
Case Management Services
Client Chart Abstraction Instrument

Section 1. Reviewer Information

Instructions:
Complete the requested information.

1.1	Date of review	
1.2	Name of reviewer	
1.3	Client chart ID#	
1.4	Time start chart review	
1.5	Time end chart review	
1.6	Total time for chart review (# minutes)	
1.7	Chart start date (Date of first entry)	
1.8	Chart end date (Date of last entry)	
1.9	Dates of services reviewed in chart	1/1/01 to 12/31/01 (Default) ___ / ___ / _____ to ___ / ___ / _____
1.10	Was chart **opened/case management services initiated** during CY2001?	☐ Yes ☐ No; chart opened prior to 2001 ☐ Not documented
1.10	Was **chart closed/client terminated** from case management services during CY2001?	☐ Yes ☐ No; client continued to receive services throughout CY2001 ☐ Not documented
1.11	Agency code	
1.12	Verification of Title I eligibility [Check if documented in chart]	☐ Meets income eligibility criteria ☐ Meets HIV-infection status criteria ☐ Meets Baltimore EMA residency requirement criteria

Section 2. Client Demographics

Instructions:
Provide the requested information based on information contained in the client's case management chart.

2.1	Client date of birth	___ / ___ / _____ ☐ Age on 12/31/01 if no dob in chart ____ ☐ Not documented in chart
2.2	Gender	☐ Male ☐ Female ☐ Transgender ☐ Not documented in chart
2.3	Race/Ethnicity	☐ White ☐ Black/African-American ☐ Hispanic/Latino/a ☐ Asian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other: Specify: ☐ Not documented in chart
2.4	HIV risk factor	☐ Men who have sex with men (MSM) ☐ Injecting drug user (IDU) ☐ MSM and IDU ☐ Heterosexual contact ☐ Heterosexual contact and IDU ☐ Hemophilia/coagulation disease or receipt of blood products ☐ Perinatal transmission ☐ Other: Specify: ☐ Undetermined/unknown ☐ Not documented in chart
2.5	Client health insurance on 1/1/01 (or first entry in 2001) ***[Check all that apply]***	☐ None ☐ Medicaid ☐ CHIPS ☐ Maryland AIDS Drug Assistance Program ☐ Medicare ☐ Private/Commercial ☐ Veteran's Administration ☐ Corrections ☐ Unknown [client reports not knowing] ☐ Other: Specify: ☐ Not documented in chart
2.6	Client health insurance on 12/31/01 (or last entry in 2001) ***[Check all that apply]***	☐ None ☐ Medicaid ☐ CHIPS ☐ Maryland AIDS Drug Assistance Program ☐ Medicare ☐ Private/Commercial ☐ Veteran's Administration ☐ Corrections ☐ Unknown [client reports not knowing] ☐ Other: Specify: ☐ Not documented in chart

2.7	Zip code for client residence on 1/1/01 (or first entry in 2001)	_____ ☐ Unknown ☐ Not documented in chart If zip code is unknown, then list city client living in on 1/1/01 or first entry in CY2001:
2.8	Locations where client received HIV-related primary care during CY2001	***Write agency names below:*** ☐ Unknown; client does not remember agency names ☐ Client reports not receiving HIV-related primary care during CY 2001 ☐ Not documented in chart
2.9	HIV disease status on 1/1/01 (or first entry in 2001)	☐ HIV-positive, not AIDS Date of dx: ___/___/ ____ ☐ Date not documented in chart ☐ CDC defined AIDS Date of dx: ___/___/ ____ ☐ Date not documented in chart ☐ HIV-negative Date of dx: ___/___/ ____ ☐ Date not documented in chart ☐ Unknown; client states he/she does not know HIV status ☐ Not documented in chart
2.10	HIV disease status on 12/31/01 (or last entry in 2001)	☐ Dead Date of death: ___/___/ _____ ☐ Date not documented in chart ☐ HIV-positive, not AIDS Date of dx: ___/___/ _____ ☐ Date not documented in chart ☐ CDC defined AIDS Date of dx: ___/___/ _____ ☐ Date not documented in chart ☐ HIV-negative Date of dx: ___/___/ _____ ☐ Date not documented in chart ☐ Unknown; client states he/she does not know HIV status ☐ Not documented in chart

2.11	CD4/Viral Load on 1/1/01 (or first entry in 2001)	CD4 _____ cells uL Date of test: ___/___/ _____ ☐ Date not documented in chart Viral load: _____ Date of test: ___/___/ _____ ☐ Date not documented in chart ☐ Unknown; client not tested; or client reports not knowing ☐ Not documented in chart
2.12	CD4/Viral Load on 12/31/01 (or last entry in 2001)	CD4 _____ cells uL Date of test: ___/___/ _____ ☐ Date not documented in chart Viral load: _____ Date of test: ___/___/ _____ ☐ Date not documented in chart ☐ Unknown; client not tested; or client reports not knowing ☐ Not documented in chart
2.13	Client on HAART on 1/1/01 (or first entry in 2001)	☐ Yes ☐ No ☐ Unknown; client reports not knowing ☐ Other: Specify: ☐ Not documented in chart
2.14	Client on HAART on 12/31/01 (or last entry in 2001)	☐ Yes ☐ No ☐ Unknown; client reports not knowing ☐ Other: Specify: ☐ Not documented in chart
2.15	Does chart contain signed consent for release of information?	☐ Yes ☐ No
2.16	Does chart contain signed consent to receive case management services from agency?	☐ Yes ☐ No

Section 3. Compliance with Case Management Service Standards

Instructions:
The client record should be reviewed only for the period of calendar year 2001 (CY2001). Only those phases of case management which occurred during CY2001 should be reviewed by the reviewer.

3.1 CASE MANAGEMENT PHASE 1: CONSUMER/CLIENT IDENTIFICATION

Determination of individual eligibility for service.

☐ Initial client contact with agency for services was after 1/1/01
▶ GO TO 3.1.a, below

☐ Initial client contact with agency for services was before 1/1/01
▶ GO TO 3.2, p. 6

☐ Record does not adequately document when client initiated agency for services
▶ GO TO 3.2, p. 6

	Standard	Standard Met	Notes
3.1.a	Agency shall screen all individuals who call, walk-in, or schedule an appointment for case management to determine appropriateness for agency services, including verification of HIV status.	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met.	
3.1.b	Agency shall make suitable referrals for those who are not appropriate for agency's case management services, but who are in need of services.	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met. ☐ This standard not applicable to this client's situation: ☐ Client was appropriate for agency's case management services; no referrals needed	
3.1.c	Agency shall assess individuals in crisis to determine what agency intervention are appropriate.	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met.	

3.2 **CASE MANAGEMENT PHASE 2: INTAKE**

☐ Client completed intake during review period (after 1/1/01)
▶ GO TO 3.2.a, below

☐ Client completed intake before review period (before 1/1/01)
▶ GO TO 3.3, p. 7

☐ Record does not adequately document when client completed intake
▶ GO TO 3.3, p. 7

	Standard	Standard Met	Notes
3.2.a	Level of Case Management client received during review period	☐ Intensive ☐ Intermediate/Periodic ☐ Limited/One-Time ☐ Multiple levels: Client reassessed to a different level of service ☐ Client record does not adequately document level of case management for client	
3.2.b	Agency shall complete an initial assessment on eligible clients at time of intake; collecting all information outlined on agency's intake forms. *Completion of intake forms is required for intensive and intermediate/periodic case management.*	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met. ☐ This standard not applicable to this client's situation; specify: ☐ Receiving limited or one-time case management level ☐ Other: Specify:	
3.2.c	Clients presenting with emergency needs will have those needs addressed by the conclusion of the intake appointment. *Emergency needs are defined as needs that will have serious immediate consequences for the client unless these needs are met.*	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met. ☐ This standard not applicable to this client's situation; specify: ☐ Client did not present with an emergency need at time of intake ☐ Other: Specify:	
3.2.d	Client will be seen for first case management appointment within 5 working days after assignment to a case manager. Clients requiring an off-site visit must be seen within 10 working days after assignment to case manager. Exceptions are made if client initiates cancellation.	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met.	

3.2.e	Agency shall assist the client in identifying and making an appointment with a medical provider for those not already connected to a primary medical care provider. *Client is to schedule his/own own appointment if able.*	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met. ☐ This standard not applicable to this client's situation; specify: ☐ Client already connected to primary medical care provider ☐ Client declines assistance. ☐ Other: Specify:

3.3 **CASE MANAGEMENT PHASE 3: PSYCHOSOCIAL NEEDS ASSESSMENT/RESOURCE IDENTIFICATION**

☐ Needs assessment completed during review period (after 1/1/01) ▸
▸ GO TO 3.3,a, below

☐ Needs assessment completed before review period (before 1/1/01)
▸ GO TO 3.4, p. 8

☐ Record does not adequately document when client completed needs assessment
▸ GO TO 3.4, p. 8

	Standard	Standard Met	Notes
3.3.a	Case manager shall complete a comprehensive written psychosocial needs assessment for each client within 30 days or by the conclusion of the 3rd case management visit, whichever comes first. The needs assessment shall include a medical/psychosocial history and shall be included in the client record. *Written assessment is required for intensive and intermediate/periodic case management.*	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met. ☐ This standard not applicable to this client's situation; specify: ☐ Receiving limited or one-time case management level ▸ GO TO 3.3.c, p. 8 ☐ Other: Specify: Check areas contained in assessment: ☐ Presenting problem ☐ Medical history ☐ Living situation ☐ Family composition ☐ Psychiatric/mental health history ☐ Spirituality issues ☐ Legal history ☐ Social/community supports ☐ Recreational/social activities ☐ Emotional/behavioral status ☐ Physical/sexual abuse history ☐ Financial status/entitlement(s) ☐ Sexuality issues ☐ Health insurance/ prescription plans ☐ Awareness of safer sex practices ☐ Employment history ☐ Current health status ☐ Substance abuse history ☐ Health symptoms ☐ Current medications ☐ Nutritional status	

3.3.b	Case manager shall ensure that client chart contains written indication that current needs have been discussed and/or identified at time of needs assessment (3.3.a). Case manager should review the listed areas of consumer/client needs when performing needs assessment (3.3.a).	☐ Yes, chart contains evidence that standard was met. ▶ GO TO 3.4, below ☐ No, chart does not contain evidence that standard was met. ▶ GO TO 3.4, below ☐ This standard not applicable to this client's situation; specify: ☐ Receiving limited or one-time case management level ▶ GO TO 3.3.c, below ☐ Other: Specify:
3.3.c	Agency should ensure that a mini-assessment specific to the client-identified problem is completed for any individual requesting limited/one time intervention (3.3).	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met. ☐ This standard not applicable to this client's situation; specify: ☐ Receiving intensive or Intermediate/periodic case management ☐ Other: Specify:

3.4 CASE MANAGEMENT PHASE 4: DEVELOPMENT OF THE CLIENT PLAN OF CARE

☐ Client plan of care completed during review period (after 1/1/01)
▶ GO TO 3.4.a, below

☐ Client plan of care completed before review period (before 1/1/01)
▶ GO TO 3.5, p. 9

☐ Record does not adequately document when client completed client plan of care
▶ GO TO 3.5, p. 9

	Standard	Standard Met	Notes
3.4.a	Case manager shall, with active participation of client, identify which needs are to be addressed through the development of goals and objectives. Establish time frames for meeting goals and resolving the problem. Incorporate written objectives and goals into the plan of care, which is a permanent part of the client chart.	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met. ☐ This standard not applicable to this client's situation; specify: ☐ Receiving limited or one-time case management level ▶ GO TO 3.5, p. 9 ☐ Other: Specify:	

3.4.b	Development of the plan of care should be started by the 3rd case management visit or within 30 working days from the date of assignment to a case manager.	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met.
3.4.c	All plans of care should be signed and dated by both the client and case manager.	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met.
3.4.d	Agency, together with client, shall identify appropriate resources needed to attain stated goals and objectives. Resources shall be written into plan of care.	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met.

3.5 CASE MANAGEMENT PHASE 5: IMPLEMENTATION AND COORDINATION OF CLIENT PLAN

▶ This section is to be completed for all clients

Case manager provides support, advocacy, consultation and other crisis intervention to the client and others involved in the implementation.

	Standard	Standard Met	Notes
3.5.a	Case manager shall proactively attempt to contact client after the development of the plan to implement those parts that were not executed at the time of plan development. Plan will establish priorities among the identified needs.	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met.	
3.5.c	Case manager shall document in writing all referrals and outcomes initiated and/or completed as they relate to the plan of care. Any corresponding actions initiated by the client/other identified people and the outcomes resulting from these actions shall be incorporated into the client record.	☐ Yes, chart contains evidence that standard was **FULLY** met. ☐ Yes, chart contains evidence that standard was **only PARTIALLY** met. ☐ No, chart does not contain evidence that standard was met.	

3.6 **Case Management**
Phase 6: Monitoring the Client Plan

Case manager shall monitor the goals and objectives contained in the client plan to decide what steps need to take, if any.

▶ This section is to be completed for all clients

	Standard	Standard Met	Notes
3.6.a	Documentation of the monitoring process shall be recorded in the client record. Monitoring shall occur at a minimum of the following: (Check level(s) received during CY2001) ☐ **Intensive case management:** - A minimum of 1 contact per month - 1 face-to-face contact every 6 months ☐ **Intermediate/periodic case management** - Case manager initiates a minimum of 1 contact every 3 months - 1 face-to-face contact every 6 months ☐ **Limited intervention** - Case manager is involved in no more than 2 contacts limited to particular issues.	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met.	
3.6.b	If a client cannot be located after several attempts to reach by telephone and/or letter, for 2 months, then a referral is made to case finding to assist in locating the client.	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met. ☐ This standard not applicable to this client's situation; specify: ☐ Level of client contact appropriate, referral to case finding not required. ▶ GO TO 3.6.e, p. 11 ☐ Other: Specify:	

3.6.c	If the client cannot be located within 90 days, the case management record is moved to inactive status.	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met. ☐ This standard not applicable to this client's situation; specify: ☐ Client located within 90 day time period, movement to inactive status not necessary. ▶ GO TO 3.6.e, below ☐ Other: Specify:
3.6.d	At end of year, if there is no contact, then the case management record is closed (for intensive and intermediate).	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met. ☐ This standard not applicable to this client's situation; specify: ☐ Client located, movement to closure status not necessary. ☐ Client receiving limited/one-time case management. ☐ Other: Specify:
3.6.e	Case manager shall provide written documentation (progress notes) of any difficulties encountered in achieving the goals and objectives and provide written strategies for resolving these difficulties.	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met.

3.7 **CASE MANAGEMENT**
PHASE 7: RE-EVALUATION OF THE PLAN OF CARE

Case manager shall review the success of the implementation of the plan of care and to determine if the client's needs have significantly changed; if needs have changed, then a new client plan shall be developed; if the needs are the same, then the current plan is continued for 1 year.

☐ Plan of care re-evaluated during review period (after 1/1/01)
▶ GO TO 3.7.a, below

☐ Plan of care re-evaluated before review period (before 1/1/01)
▶ GO TO 3.8, p. 13

☐ Record does not adequately document whether re-evaluation was carried out
▶ GO TO 3.8, p. 13

	Standard	Standard Met	Notes
3.7.a	Each agency shall assess the client records a minimum of every 6 months to determine the client's status and progress and whether any revision is needed in the care plan or in the provision of services. • Record review in the progress notes. • Record review may be done by the case manager, supervisor, peer review, formal audit, etc.	☐ Yes, chart contains evidence that standard was met. ▶ **If Yes,** check who conducted the re-evaluation (check all that apply) ☐ client's case manager ☐ supervisor ☐ peer review ☐ formal audit ☐ other; specify ☐ No, chart does not contain evidence that standard was met.	
3.7.b	The case manager shall develop, with the active participation of the client, new goals and objectives if the needs have changed since the previous needs assessment.	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met. ☐ This standard not applicable to this client's situation; specify: ☐ Client needs determined not to have changed since the previous needs assessment ☐ Other: Specify:	

3.8 CASE MANAGEMENT PHASE 8: CLOSURE

Reason documented for closure of the case:
Check applicable:
☐ At the request of the client;
☐ At the request of the agency (provided that pre-established procedures are followed)
☐ Lack of client contact; see standard 3.6.d
☐ Due to client death
☐ Client relocated
☐ Client case management services transferred to another case management agency
☐ Reason for closure not documented
☐ Other: specify

☐ Case was not closed during the review period
▶ GO TO 4.0, p. 14

☐ Case was closed during review period.
▶ GO TO 3.8.a, below

☐ Record does not adequately document whether case was closed during the review period
▶ GO TO 4.0, p. 14

	Standard	Standard Met	Notes
3.8.a	Prior to closure (with the exception of death), the agency shall attempt to inform the client of the re-entry requirements into the system, and make explicit what case closing means to the client.	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met.	
3.8.b	The agency shall close a client file according to the procedures established by the agency.	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met.	

Section 4. Service Outcomes

Instructions:
This section should be completed only for clients who had a care plan in CY2001. Reviewers are asked to determine A) whether an unmet need was identified during the intake/assessment in six areas (income assistance, health insurance, housing, primary health care provider, substance abuse treatment services, emotional counseling), and, if the unmet need was identified, then determine: B) whether a goal to meet this unmet need was established in the care plan; C) whether the chart contains documentation relating to case management activities performed to meet this unmet need; and D) whether the unmet need was met.

5 If the chart does not contain a client case plan, check here: ☐ ▶ END OF CHART REVIEW

4.1 **Income Assistance** Definition of unmet need: • Being unemployed; and/or • Not receiving any public assistance (SSI, SSDI, TANF) Definition of met need: • Being employed; and/or • Receiving some public assistance (SSI, SSDI, TANF)	A. Was unmet need for income assistance Identified in most recent/latest intake/assessment? ☐ Yes ☐ No ▶ GO TO 4.2, p. 15 ☐ No intake/assessment in chart ▶ GO TO 4.2, p. 15 B. Was goal established in most recent/latest care plan to address need for income assistance? ☐ Yes ☐ No ☐ No care plan in chart C. Is there documentation in chart relating to case management activities performed to address the need for income assistance? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the Identified need for income assistance met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.2 **Health insurance** Definition of unmet need: • Having no health insurance; and/or • Having inadequate insurance to meet needs (e.g., medications) Definition of met need: • Having a form of health insurance; and/or • Having insurance to meet unmet need (e.g., MADAP)	A. Was unmet need for health insurance Identified in most recent/latest intake/assessment? ☐ Yes ☐ No ▶ GO TO 4.3, below ☐ No intake/assessment in chart ▶ GO TO 4.3, below B. Was goal established in most recent/latest care plan to address need for Health insurance? ☐ Yes ☐ No ☐ No care plan in chart C. Is there documentation in chart relating to case management activities performed to address the need for Health insurance? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the Identified need for Health insurance met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.3 **Housing** Definition of unmet need: • Being unstably housed; or • Living in shelter; SRO; doubled-up with friend/relative; hospital-nursing home-residential care facility and medically ready for discharge; or • Living in situation other than ones own house, apartment, supported living Definition of met need: • Being stably housed • Living in ones own house, apartment, supported living	A. Was unmet need for housing Identified in most recent/latest intake/assessment? ☐ Yes ☐ No ▶ GO TO 4.4, p. 16 ☐ No intake/assessment in chart ▶ GO TO 4.4, p. 16 B. Was goal established in most recent/latest care plan to address need for housing? ☐ Yes ☐ No ☐ No care plan in chart C. Is there documentation in chart relating to case management activities performed to address the need for housing? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the Identified need for housing met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.4 **Primary Health Care Provider** Definition of unmet need: • Not being able to Identify a primary health care provider/agency from whom the patient can receive routine, non-emergent care related to HIV disease and other health care needs Definition of met need: • Being able to Identify a primary health care provider/agency from whom the patient has received routine, non-emergent care related to HIV disease and other health care needs • Being able to report current CD4 count, viral load, treatment regimen	A. Was unmet need for primary health care provider Identified in most recent/latest intake/assessment? ☐ Yes ☐ No ▸ GO TO 4.5, below ☐ No intake/assessment in chart ▸ GO TO 4.5, below B. Was goal established in most recent/latest care plan to address need for primary health care provider? ☐ Yes ☐ No ☐ No care plan in chart C. Is there documentation in chart relating to case management activities performed to address the need for primary health care provider? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the Identified need for primary health care provider met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.5 Substance Abuse Treatment Services Definition of unmet need: • Self reported drug and /or alcohol use and/or dependence during period before Intake • Use of Illicit drugs/prescription drugs known to cause dependence • Use of more drugs than intended • Presence of emotional/psychiatric problem associated with drug use Definition of met need • Having received professional substance abuse services or participating in a self-help group	A. Was unmet need for substance abuse treatment services Identified in most recent/latest intake/assessment? ☐ Yes ☐ No ▸ GO TO 4.6, p. 17 ☐ No intake/assessment in chart ▸ GO TO 4.6, p. 17 B. Was goal established in most recent/latest care plan to address need for substance abuse treatment services? ☐ Yes ☐ No ☐ No care plan in chart C. Is there documentation in chart relating to case management activities performed to address the need for substance abuse treatment services? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the identified need for substance abuse treatment services met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.6 **Emotional Counseling** Definition of unmet need: • Self reported. Definition of met need: • Having seen a mental health provider, attended a support group, or seen a spiritual provider.	A. Was unmet need for emotional counseling Identified in most recent/latest intake/assessment? ☐ Yes ☐ No ▶ END OF CHART REVIEW ☐ No intake/assessment in chart ▶ END OF CHART REVIEW B. Was goal established in most recent/latest care plan to address need for emotional counseling? ☐ Yes ☐ No ☐ No care plan in chart C. Is there documentation in chart relating to case management activities performed to address the need for emotional counseling? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the identified need for emotional counseling met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

■ END OF CHART REVIEW

BCHD Quality Improvement Project
Case Management Services
Agency Survey

- Agency Name:
- Address:
- Person completing form:
- Telephone:
- Fax:
- e-mail:

Please check all of the services that your agency **directly provided,** on-site during calendar year 2001. **Note**: Do not limit your responses only to services funded by Ryan White Care Act.

- ☐ Ambulatory Health Care
- ☐ Mental Health Services
- ☐ Outreach
- ☐ Substance Abuse Treatment
- ☐ Transportation
- ☐ Buddy/ Companion
- ☐ Case Management
- ☐ Client Advocacy
- ☐ Counseling
- ☐ Dental Care
- ☐ Direct Emergency Assistance
- ☐ Food/ Nutrition
- ☐ Housing Assistance
- ☐ Legal Services
- ☐ Enriched Life Skills
- ☐ Co-morbidity Services
- ☐ Viral Load Testing
- ☐ Other/ Specify:

Please check all of the services that your agency does not directly provide on-site, but have **established referral agreements** with other agencies to provide these services to your clients during calendar year 2001. . **Note**: Do not limit your responses only to services funded by Ryan White Care Act.

- ☐ Ambulatory Health Care
- ☐ Mental Health Services
- ☐ Outreach
- ☐ Substance Abuse Treatment
- ☐ Transportation
- ☐ Buddy/ Companion
- ☐ Case Management
- ☐ Client Advocacy
- ☐ Counseling
- ☐ Dental Care
- ☐ Direct Emergency Assistance
- ☐ Food/ Nutrition
- ☐ Housing Assistance
- ☐ Legal Services
- ☐ Enriched Life Skills
- ☐ Co-morbidity Services
- ☐ Viral Load Testing
- ☐ Other/ Specify:

Standards of care

A. Licensing

1. Is the agency licensed by an appropriate body?

   ☐ Yes ☐ No

2. Where applicable, do staff have licenses that are current and appropriate for providing case management services?

   ☐ Yes ☐ No

B. Training and Supervision

3. Are case management services provided directly by, or under supervision of, or in consultation with a licensed social worker and/ or registered nurse case manager?

   ☐ Yes ☐ No

4. Does the agency have written policies that encourage and allow continuing education and professional development opportunities to be pursued on a regular basis?

   ☐ Yes ☐ No

5. Does the agency maintain documentation for each staff person of all in-service and/ or specialized training, given or taken, on pertinent topics related to HIV/ AIDS?

   ☐ Yes ☐ No

6. Does the agency have a system that regularly updates the staff of available services for people living with HIV/ AIDS?

   ☐ Yes ☐ No

   ▸ If Yes, describe this system?

C. Practice

7. Does the agency have written policies and procedures regarding:

☐ Yes ☐ No	a. Eligibility for service
☐ Yes ☐ No	b. Determining level of case management services
☐ Yes ☐ No	c. Timeframe for addressing emergency needs identified during Intake
☐ Yes ☐ No	d. Timeframe for scheduling of first case management appointment
☐ Yes ☐ No	e. Timeframe for completion of written psychosocial needs assessment
☐ Yes ☐ No	f. Development of client plan of care
☐ Yes ☐ No	g. Timeframe for the development of client plan of care
☐ Yes ☐ No	h. Review of plan of care with client and signing and dating of plan of care by both case manager and client
☐ Yes ☐ No	i. Documentation of referrals and outcomes
☐ Yes ☐ No	j. Frequency of case manager-initiated contacts with clients receiving case management services
☐ Yes ☐ No	k. Timeframe for re-evaluation of client plan of care
☐ Yes ☐ No	l. Timeframe for referral of clients lost to follow-up for case finding assistance
☐ Yes ☐ No	m.Time frame for moving client file to Inactive status
☐ Yes ☐ No	n. Timeframe for closure of case management file
☐ Yes ☐ No	o. Informing client regarding termination of case management services and requirements re-entry for case management services
☐ Yes ☐ No	p. Closure of client file

Client record closure

8. Are records for adult clients (over 18 years) kept for a minimum of ten years after last record entry?

☐ Yes ☐ No ☐ Not applicable, agency does not serve adults

9. Are records for children clients (over 19 years) archived until the child reaches the age of 24 or six years after death, if sooner?

☐ Yes ☐ No ☐ Not applicable, agency does not serve children

D. Consumer/ Client Rights and Responsibilities

10. Does the agency have a written policy on confidentiality?

    ☐ Yes ☐ No

11. Does the agency routinely provide to clients copies of eligibility criteria and services available?

    ☐ Yes ☐ No

12. Does the agency routinely ask clients to sign a written consent of the release of information?

    ☐ Yes ☐ No

13. Does the agency have a written grievance procedure?

    ☐ Yes ☐ No

14. Does the agency have a statement of client rights as well as responsibilities or agency expectations of each client?

    ☐ Yes ☐ No

15. Does the agency have a statement that outlines the process for both voluntary and involuntary disengagement from services?

    ☐ Yes ☐ No

16. Does the agency routinely explain to clients existing agency policies and procedures regarding confidentiality, grievance, eligibility and service?

    ☐ Yes ☐ No

17. Does the agency routinely ask clients to sign a statement and include this statement in the client record verifying that these policies and procedures have been explained?

    ☐ Yes ☐ No

E. Quality Assurance

18. Does the agency have a quality assurance plan to monitor both appropriateness and effectiveness of case management services?

☐ Yes ☐ No

19. Does the agency have a process for clients to evaluate the agency, staff and services?

☐ Yes ☐ No

- If Yes, describe this process?

CATEGORY: CASE MANAGEMENT

ratified: October, 1998.

DEFINITION

Case management is defined as a discrete service through which multiple psychosocial service needs of clients are met in order to maximize continuity for quality care. Case management practice components include:

A. HEALTH-PSYCHOSOCIAL ASSESSMENT
B. CARE PLANNING
C. PROCUREMENT OF SERVICES
D. LINKAGE WITH SERVICES
E. DELIVERY OF SERVICES
F. ADVOCACY
G. ON-GOING MONITORING

CATEGORY: CASE MANAGEMENT

STANDARDS OF CARE 1.0

Case Management services are directed toward ensuring the timely and coordinated access to medically necessary and appropriate levels of care and support services that enhance continuity of care across the continuum of service providers.

The following are minimum standards for the provision of Case Management Services.

Agencies and individuals may exceed these minimum standards.

The level of Case Management service is determined by the Case Manager and the consumer/client beginning at assessment and should be changed as consumer/client needs change.

1.0 LEVELS OF CASE MANAGEMENT

1.1 INTENSIVE

a. Duration of relationship expected to last as long as program participation.
b. Significant involvement in coordinating services to consumer/client and/or family and household members.
c. Problem solving spans medical, mental health/substance abuse, social services, and support services. Follow-up on referrals required.
d. Consumer/client will receive a minimum of one (1) face to face contact per month from Case Manager. If the consumer/client does not follow through with scheduled appointments, the Case Manager will initiate contact.
e. Each consumer/client will have an initial plan of care written up. This care plan will be arrived at by mutual agreement during the assessment phase of service. The plan must be completed within two (2) months of the first interview. Written re-evaluation of the care plan will occur once every six (6) months. The agency shall continue with current client plan for one (1) year if the client's needs have not changed.

1.2 INTERMEDIATE OR PERIODIC

a. Duration of relationship expected to last as long as program participation.
b. Level of Case Manager's involvement in coordinating services to the consumer/client and/or family and household members will be determined by the consumer/client's needs for intervention.
c. Problem solving spans medical, mental health/ substance abuse, social services and support services and referrals. Follow-up by Case Manager on referrals will be determined by consumer/client's needs for such interventions.
d. Contact will be initiated by Case Manager or consumer/client at least every three (3) months and at least one (1) face to face contact a year.
e. Each consumer/client will have a written initial plan of care which will be re-evaluated at least annually.

1.3 LIMITED OR ONE TIME INTERVENTION

a. Clients receive a mini assessment specific to client identified problem, other issues and problems may be identified at this point. Intervention is documented.
b. Duration of relationship may be limited to specific issues.

c. Problem solving limited to resource identification.
d. Case Manager is expected to have no more than two (2) contacts. If more follow-up is necessary within a 90 day period from the initial contact, the Case Manager will re-assess the level of Case Management for appropriateness.
e. No plan of care is necessary.

2.0 PRACTICE GUIDELINES

2.1 CONSUMER/CLIENT IDENTIFICATION

To determine if an individual is eligible for services by virtue of pre-established criteria developed by the service provider.

a. The agency shall screen all individuals who call, walk-in, or schedule an appointment for Case Management services to determine the appropriateness for agency services, including verification of HIV status.
b. The agency shall make suitable referrals for those individuals who are not appropriate for agency Case Management services, but who are in need of services.
c. The agency shall assess individuals in crisis to determine what agency interventions are appropriate.
d. The agency may assign a Case Manager to eligible consumer/clients at the time of their initial contact.

2.2 INTAKE

To formally enter an eligible consumer/client into the system for further assessment and the development of the client's plan of care, it is necessary to collect all information about the consumer/client for subsequent planning, intervention and/or intake.

a. The agency shall complete an initial assessment on eligible consumer/clients at the time of intake, collecting all information as outlined on the service provider's intake forms.

Completion of these forms is required for Intensive and Intermediate Case Management.

b. Eligible consumer/clients presenting with emergency needs will have those needs addressed by the conclusion of the intake appointment. Emergency needs are defined as needs that will have serious immediate consequences for the consumer/client unless these needs are met.
c. Consumer/clients will be seen for the first Case Management appointment within five (5) working days after assignment to a Case Manager. Individuals requiring an off-site visit must be seen within ten (10) working days after assignment to a Case Manager. Exceptions are made if consumer/clients initiate cancellations.
d. The agency shall assist the consumer/client in identifying and making an appointment with a medical provider as early as possible during the time of the initial intake or the Case Management intake appointment for those consumer/clients not already connected to a primary medical care provider.

Consumer/clients are to schedule their own appointments if they are able.

2.3 PSYCHOSOCIAL NEEDS ASSESSMENT/REOURCE IDENTIFICATION

a. The Case Manager shall complete a comprehensive written psychosocial needs assessment for each consumer/client within thirty (30) days or by the conclusion of the third Case Management appointment, which ever comes first. This needs assessment shall include a medical/psychosocial history and shall be included in the consumer/client record. This is required for Intensive and Intermediate Case Management.

Areas to be covered in the psychosocial assessment:

- Presenting Problem(s)
- Living Situation
- Nutritional Status History
- Spirituality Issues
- Social/Community Supports
- Emotional/Behavioral Status
- Financial Status/Entitlement(s)/Health Insurance/Prescriptions Plan(s)
- Sexuality Issues
- Awareness of Safer Sex Practices
- Current Health Status
- Health Symptoms
- Medical History
- Family Composition*
- Psychiatric/mental health
- Legal History
- Recreational/Social Activities
- Physical/Sexual Abuse History
- Employment History
- Substance Abuse History
- Current Medications

*It is recommended that children, thirteen (13) and under, be HIV tested if either parent is HIV+.

a. The Case Manager shall ensure that each consumer/client chart contains written indications that the current needs have been discussed and/or identified at the time of the psychosocial needs assessment. Case Managers should review the listed areas of consumer/client needs when performing the psychosocial needs assessment.
b. The agency should ensure that a mini assessment specific to the consumer/client identified problems is completed for any individuals requesting Limited or One Time Interventions.

2.4 DEVELOPMENT OF THE CONSUMER/CLIENT PLAN OF CARE

With the active participation of the consumer/client and possibly others, e.g. partners, parents, guardians, medical care givers, the Case Manager shall develop an appropriate course of action to access the identified resources required to meet the needs and resolve the problems.

a. The Case Manager shall, with the active participation of the consumer/client, identify which needs are to be addressed through the development of goals and objectives. Time frames for meeting the goals and resolving the problems should also be established. These written objectives and goals are to be incorporated into the plan of care which is a permanent part of the consumer/client chart. Development of the plan of care shall be started by the third Case Management appointment or within thirty (30) working days from the date of the assignment to a Case Manager. No plan of care is necessary for limited or one time intervention. All plans of care should be signed and dated by both the consumer/client and the Case Manager.
b. The agency shall, together with the consumer/client, identify the appropriate resources needed to attain the stated goals and objectives. This resource identification shall be written in the plan of care.
c. The agency shall provide written verification that the consumer/client is either in agreement or disagreement with the goals and objectives contained in the plan of care.

2.5 IMPLEMENTATION AND COORDINATION OF CONSUMER/CLIENT PLAN

The case manager provides support, advocacy, consultation, and crisis intervention to the client and others involved in the implementation of the plan.

a. The Case Manager shall proactively attempt to contact the consumer/client after the development of the plan to implement those parts that were not executed at the time of the plan development. The plan will establish priorities among the identified needs.

b. The Case Manager shall advise the client on making arrangements with service

providers selected and on ways of gaining access to those services.

c. The Case Manager shall document in writing all referrals and outcomes initiated and/or completed as they relate to the plan of care. Any corresponding actions initiated by the client and other identified people and the outcomes resulting from these actions shall also be incorporated in the consumer/client record.

d. The Case Manager shall be in communication with the consumer/client during the Intensive level of Case Management, a minimum of one (1) contact per month to provide support, advocacy, consultation, and crisis intervention throughout implementation of the client plan. For Intermediate Case Management, the Case Manager shall be in communication with the consumer/client a minimum of once every three (3) months. There shall be at least one (1) face to face contact a year for the Intermediate Case Management level and one (1) face to face contact every six (6) months at the Intensive level.

2.6 MONITORING THE CONSUMER/CLIENT PLAN

Monitoring is performed to routinely review the success in accessing services as outlined in the consumer/client care plan, to measure progress in meeting goals and objectives, to intervene as appropriate and to revise the plan as necessary.

a. The Case Manager shall monitor the goals and objectives contained in the consumer/client plan (as the needs of the consumer/client require) to decide what steps need to take, if any. Documentation of the monitoring process shall be recorded in the consumer/client record. This monitoring shall occur a minimum of the following:

Intensive	Each client receives a minimum of one (1) contact per month from the case manager (two (2) face to face contacts a year - one (1) face to face every six (6) months)
Intermediate or Periodic	Contact can be initiated by Case Manager or consumer/client at least every three (3) months (one (1) face to face contact a year)
Limited or One Time	Case Manager is involved in no more than two (2) Intervention contacts limited to particular issues.

If a client cannot be located, after several attempts to reach by telephone and/or letter, for two (2) months, a referral is made to case finding (if available) to assist in locating the client. If the client cannot be located by the case finder within ninety (90) days, the case management record is moved to inactive status. At the end of a year, if there is no contact, the case management record is closed (for comprehensive and intermediate.)

b. The Case Manager shall monitor the services provided and the services delivery to verify that the services are being received and are sufficient in quality and quantity.

c. The Case Manager shall provide written documentation (in the progress notes) of any difficulties encountered in achieving the goals and objectives, and provide strategies in writing for resolving these difficulties.

d. The Case Manager shall make available professional supervision or consultation to all Case Managers while the plan of care is being monitored. A minimum of one hour of formal supervision once a month is required per Case Manager, with

additional case consultations on an as-needed mutually determined basis.

2.7 RE-EVALUATION OF THE PLAN OF CARE

To review the success of the implementation of the care plan and to determine if the consumer/client's needs have significantly changed since the previous needs assessment. If the needs have changed, then a new consumer/client plan should be developed. If the needs are the same, then the current plan is continued for one (1) year.

a. Each agency shall assess the consumer/client records a minimum of every six (6) months to determine the consumer/client's status and progress and whether any revision is needed in the care plan or in the provision of services. This review shall be recorded in the progress notes. The record review may be done by the Case Manager supervisor, peer review, formal audit,

b. The Case Manager shall develop, with the active participation of the consumer/client, new goals and objectives if the needs have changed since the previous needs assessment.

2.8 CLOSURE

Closure of the case at the request of the client, at the request of the agency (provided that pre-established procedures are followed), or due to death.

a. Prior to closure (with the exception of death), the agency shall attempt to inform the consumer/client of the re-entry requirements into the system, and make explicit what case closing means to the consumer/client.
b. The agency shall close a consumer/client's file according to the procedures established by the agency.
c. In Maryland, adult (over 18) records will be kept for a minimum of ten (10) years after last entry. For children (under 19) the record must be archived until the child reaches the age of 24 or six (6) years after death, if sooner.

3.0 LICENSING

a. The agency/organization will show evidence of being licensed by an appropriate body.
b. Licenses must be current and available.
c. Where applicable, staff will have licenses that are current and appropriate for providing Case Management services.

4.0 TRAINING AND SUPERVISION

The agency will provide adequate training and supervision for all Case Managers.

The agency will:
a. Maintain documentation that demonstrates that Case Management services are provided directly by, or under the supervision of, or in consultation with a licensed social worker and/or registered nurse case manager.
b. Maintain documentation for each staff person of all in-service and/or specialized training, given or taken, on pertinent topics related to HIV/AIDS.
c. Have policies that encourage and allow continuing education and professional development opportunities to be pursued on a regular basis.
d. Create a system that regularly updates the staff resource information network of available services for people living with HIV/AIDS.

5.0 CONSUMER/CLIENT RIGHTS AND RESPONSIBILITIES

The agency shall have policies and procedures that protect the rights and outline the responsibilities of the consumer/clients and the agency.

These policies and procedures include:

a. A written agency policy on consumer/client confidentiality.
b. A statement signed by the consumer/client that states that existing policies and procedures regarding confidentiality, grievance, eligibility and services have been explained to the consumer/client. Copies of eligibility criteria and services available should be given to each consumer/client requesting services.
c. System for ensuring that case records are protected and secured.
c. A written, signed consent for the release of consumer/client information that pertains to establishing eligibility for agency services.
e. A written grievance procedure
f. A statement of consumer/client rights as well as responsibilities or agency expectations of each consumer/client.
g. A statement that outlines process for both Voluntary and Involuntary Disengagement from Services.

6.0 QUALITY ASSURANCE

The agency must have a quality assurance plan to monitor both appropriateness and effectiveness of Case Management Services.

This quality assurance plan, contained in the consumer/client case file, should include:

a. The mutually established plan of care.
b. A full needs assessment with psychosocial and medical needs described.
c. Documentation of the services delivered, referrals made, advocacy efforts initiated to address the needs as presented in the care plan
d. Evidence that the plan of care was reviewed at least each six (6) months and when appropriate was modified according to the medical status of the consumer/client.
e. Evidence of linking of consumer/clients with the full range of benefits and/or entitlements.
f. Evidence of linking the consumer/client with needed services such as:
    1. Medical services
    2. Substance Abuse services
    3. Mental Health services
    4. Social Services
    5. Financial services
    6. Counseling services
    7. Educational services
    8. Housing services
    9. Other support services.
g. A process for consumer/clients to evaluate the agency, staff, and services.